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National Hospital Rate-Setting Study, Vol. I

Case Study of Prospective Reimbursement in Arizona

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Case Study of Prospective Reimbursement in Arizona

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ARIZONA

Initiated in 1972, the prospective reimbursement program in Arizona is administered jointly by the Department of Health Services (DHS) and regional Health Systems Agencies (HSA). Each hospital seeking a rate increase must inform both DHS and its regional HSA in advance and submit data that can be used to evaluate the reasonableness of the proposed rate increase. Although they exchange information, DHS and the HSAs review hospital proposals independently and submit separate findings. Using panels comprised of consumers, providers, and business representatives, the HSAs conduct public hearings as an important part of the review process. Hospitals are considered to be in compliance if they follow the recommendations of either the HSAs or the DHS. Although hospitals are required by law to submit proposed rate increases for review, compliance is voluntary.

Compared to procedures used in other states, the analysis used to review hospitals' budgets in Arizona is neither elaborate nor stringent. The general criterion applied is reasonableness in relation to the hospital's objectives, its previous performance, and the expected level of inflation in the general economy. No particular costs (e.g., expenditures for research, education, bad debts) are disallowed for reimbursement purposes, and interhospital comparisons are given only minor weight in most budget reviews. Staff at the state agency compare trends over a three-year period in revenue, expense, patient mix, length of stay, and admissions. These and other summary statistics are provided to HSA panel members for use at public hearings. The discussion at hearings may focus on these statistics or on issues of particular importance to the community in which the hospital is located--for example, increases in charges for services used extensively by the elderly. Hospitals are encouraged to negotiate specific issues with review staff prior to hearings, are asked to give a presentation at hearings, and may raise questions or ask for reconsideration after preliminary recommendations have been made.

Compliance with recommendations is voluntary, so no formal enforcement procedures exist in the Arizona program. Since the total budget of a hospital is reviewed, revenues from all patients are affected by any cost containment the program achieves. The program does not set rates to be paid by any particular patients or health insurance programs. Despite the lack of legal or fiscal sanctions, compliance with recommendations has been quite high, due to the informal negotiations built into the review process, the threat of adverse public reaction, and pressure from business and community leaders.

ACKNOWLEDGMENTS

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Milton Gan, Executive Director
Central Arizona HSA

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FOREWORD

The following case study report of prospective reimbursement in Arizona has been written as part of the National Hospital Rate-Setting Study. This study is being conducted for the Office of Research, Demonstrations, and Statistics of the Health Care Financing Administration, U.S. Department of Health, Education, and Welfare, by Abt Associates Inc., Policy Analysis, Inc., and Health Economics Research, Inc.* The overall goal of the three-year study is to determine the impact of rate setting on hospital costs, quality of hospital care, and access to health care by the elderly and the economically disadvantaged. In addition, the study will examine the impact of prospective reimbursement on other areas of hospital performance, including revenues, volume and composition of services, productivity, wages, case mix, and administrative behavior. Because the effects of prospective reimbursement may be felt beyond the hospital sector, the study will also examine impacts on the costs and utilization of the health care system as a whole.

This volume is one of nine case study reports (Arizona, Connecticut, Maryland, Massachusetts, Minnesota, New Jersey, New York, Washington, and Western Pennsylvania). Each report examines in detail the adoption, implementation, review processes and legal challenges of each prospective reimbursement system. In addition, the reports examine linkages and interactions that take place between rate-setting agencies and other organizations such as planning groups, hospital associations, third party payors, and unions. Each case study also presents a preliminary analysis of the potential rigor and equity of the prospective reimbursement system. (A separate report, A Comparative Analysis of Nine Prospective Reimbursement Programs, analyzes all nine programs simultaneously along these factors.) The case study reports will be most useful to those interested in a detailed description of the prospective reimbursement programs in the nine states under study.

The preliminary analyses of rigor and equity in the case studies are interim in nature. Data collection on hospital performance is still ongoing and will yield important information about the effectiveness of administrative structures and procedures in containing costs and delivering quality service. Final results of the study are expected in 1982.

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Deputy Project Director &
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*Arthur D. Little, Inc. and Arthur Andersen & Co. are also participating in the National Hospital Rate-Setting Study but were not involved in the case studies.

INTRODUCTION

General Summary

The Arizona rate review program was implemented January 1, 1972. The enabling legislation, House Bill 15, was an omnibus health care regulation law that also authorized Certificate of Need and Uniform Accounting. Although the program's organizational locus within the state bureaucracy has changed since 1972, there have been no legislative attempts to modify the basic program content.

Major characteristics of the rate review program include:

- emphasis on rate review rather than rate setting;
- mandatory uniform accounting, annual reporting, and public disclosure of financial and operating information;
- dual-level review by Health Systems Agencies (HSAs) and a state agency;
- high degree of community involvement in the rate review process at the HSA level;
- institution-specific review (based on evaluation of budget projections and limited use of interhospital comparisons);
- review criteria as applied by individual HSAs, not uniformly across HSAs; and
- voluntary compliance with the agencies' recommendations.

Arizona's rate review program combines mandatory review with voluntary compliance and is best characterized as a rate review rather than a rate-setting program. All health care institutions, including hospitals, nursing care institutions, outpatient treatment clinics, and residential care institutions, are subject to rate review. Uniform accounting and annual reporting are also mandatory for all health care institutions. Due to budgetary restrictions, however, rate review has been implemented for hospitals and nursing care institutions only, while uniform accounting has been implemented for hospitals only. Rate review covers self-payors, Blue Cross, and other charge-based third-party payors, but not the cost-based Medicare program. Arizona does not have a Medicaid program; county governments are responsible for indigent care, and the high-population counties have county-owned hospital and nursing care facilities.

The Arizona Department of Health Services (DHS) and the HSAs share joint responsibility for the rate review program, with no other agencies directly participating in rate review. All proposed rate increases are reviewed by an HSA and by the DHS, both of which issue findings relative to justification of the proposed increases. The HSA findings are made by a volunteer review panel with consumer and provider representatives, operating under authority of the HSA's governing body.

The review process is primarily a form of budget review with some informal negotiations in cases where reductions are recommended. Each rate increase filed is evaluated as a unique case; the institution is judged by its internal financial characteristics as presented in a standard state form. There are no formal criteria for evaluating proposed rate increases that are applied consistently by the HSAs across the state, although the governing statutes specify that findings must include information on certain financial aspects such as the institution's source and application of funds. Rate reviewers attempt to determine what is a "reasonable" amount of increase in light of the hospital's present and future financial requirements and the amount of time that has elapsed since the previous increase. There is also some variation across review loci and individual reviewers as to what is considered a reasonable increase.

Any health care institution planning to implement a rate increase must undergo the mandatory review by an HSA and the DHS within a total review period of sixty days. The review process emphasizes public disclosure of information; the HSA's review includes a public hearing conducted by the HSA's review panel in which public participation is encouraged. The review cycle results in local and state agency recommendations as to the appropriate rate increase. Once the review cycle is completed and the state findings issued, the institution is not legally obliged to comply with the agencies' recommendations. Compliance is motivated, however, by several factors, including:

- the threat of negative public reaction;
- a desire to maintain good relations with review agencies in order to facilitate matters such as Certificate of Need (CON) approval;
- a concern that noncompliance might lead to a mandatory rate-setting program; and
- the recent use of findings by third-party payors.

Hospitals have rarely rejected the review findings when the HSA and the state have been in agreement. In cases of difference between the two, hospitals have generally accepted the more favorable finding. The record of compliance for nursing care institutions is less favorable.

Comparative Trends in Arizona Hospitals

This section is a presentation and brief discussion of some relevant characteristics and trends in Arizona's hospital sector as compared to those for the nation. The behavior of Arizona's and the nation's hospital sectors during the periods before (1969-1971) and after (1972-1977) the inception of the rate review program are displayed graphically in Figures 1 and 2. Trends have been indexed (1969=100) for the following variables:

- total number of beds;
- total patient days;
- occupancy;
- length of stay;
- expense per patient day;
- revenue per patient day;
- assets per bed; and
- expenses per capita.

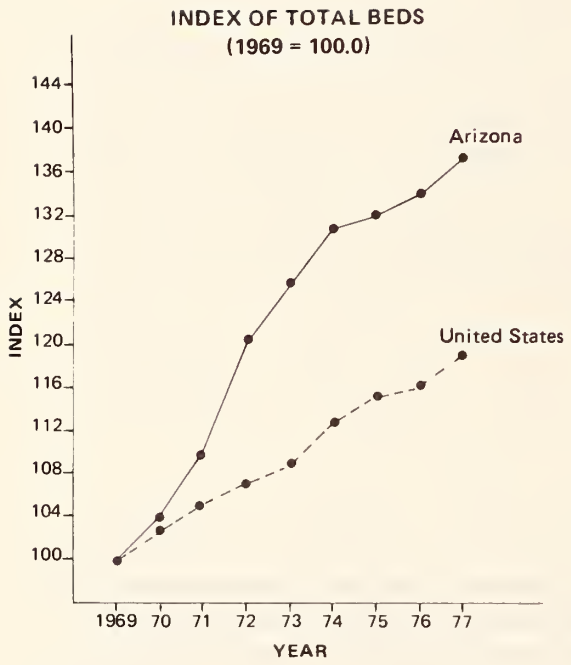
The graphs in Figure 1 essentially indicate that the output in Arizona hospitals as measured by patient days has increased about thirty-four percent, while the number of hospital beds has increased about thirty-seven percent during the nine-year period. The impact of the slightly smaller increase in output relative to the number of beds is reflected in the general declines in the state's occupancy rate and average length of stay. Figure 2 displays the change in certain aspects of the financial behavior of the state's hospitals; revenues and expenses per patient day have been rising sharply in Arizona and the rest of the country, as have assets per bed and expenses per capita. An interesting deviation revealed in the data is the apparently erratic behavior of the Arizona system in 1977, when assets per bed declined from the previous year's level while all other financial indicators rose.

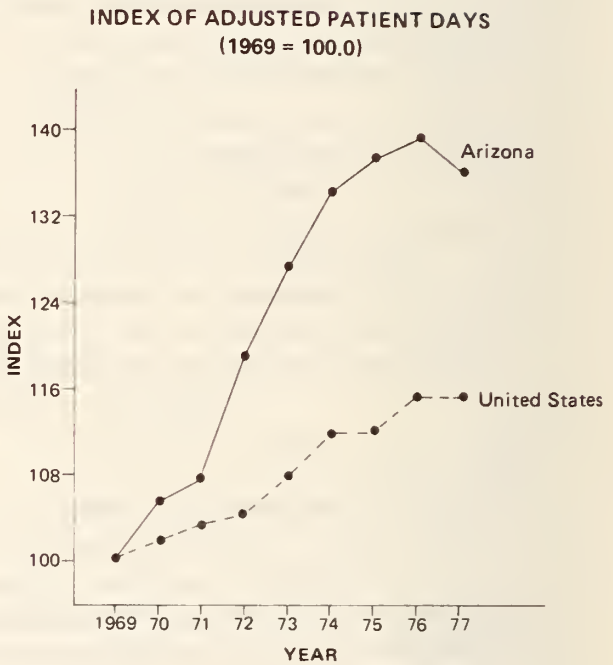
Overview

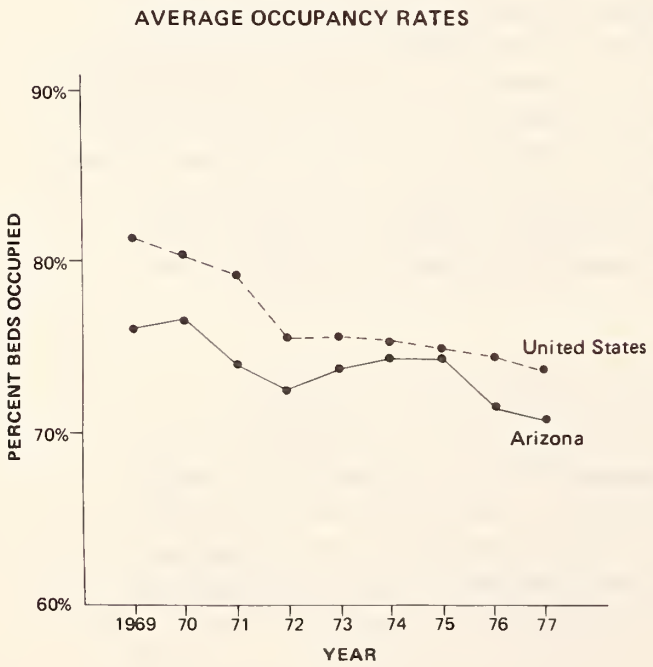
The remaining sections of this report contain descriptions of the adoption of Arizona's rate review program, the mechanics of the review process, and the program's interaction with other agencies and groups. A preliminary assessment of the program is also included. A chronology of events and the political and social pressures that led to the adoption of

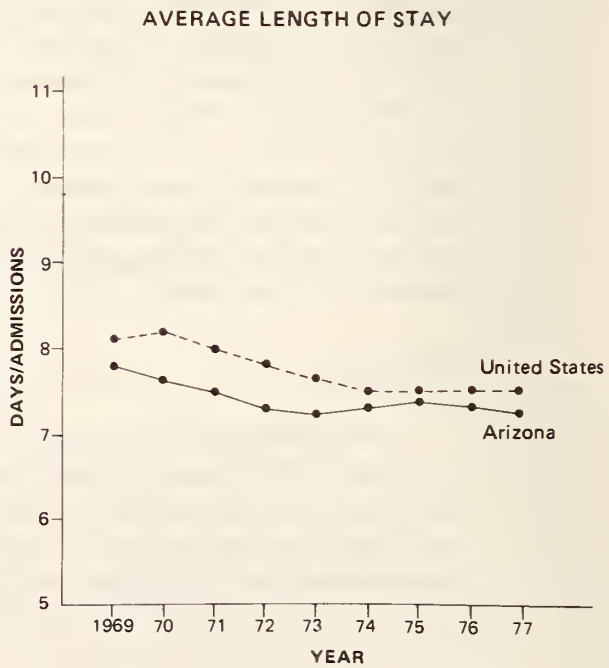
Figure 1

COMPARISON OF HOSPITAL INDICATORS:
Capacity, Volume of Service and Utilization
for Community Hospitals, 1969-1977
ARIZONA vs. U.S.







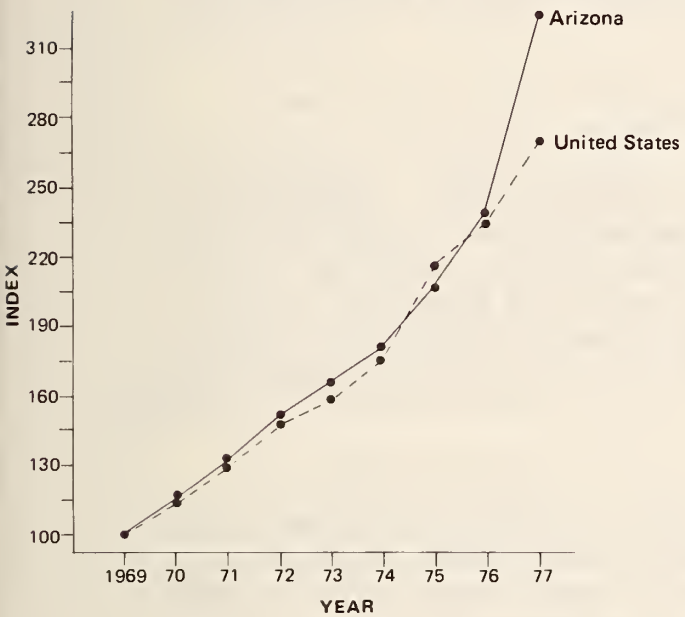


Sources: U.S. Bureau of the Census
American Hospital Association, *Hospital Statistics*

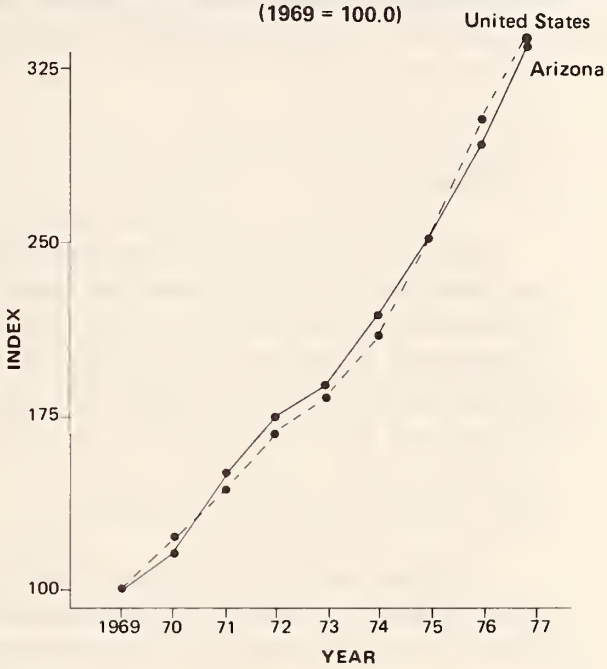
Figure 2

COMPARISON OF HOSPITAL INDICATORS:
Expense, Total Revenue and Assets
for Community Hospitals, 1969-1977
ARIZONA vs. U.S.

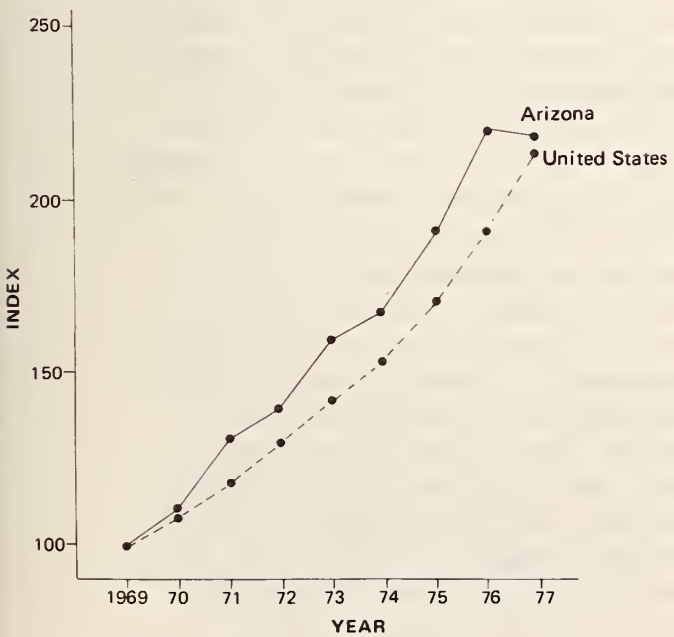
INDEX OF HOSPITAL EXPENSE PER DIEM*
(1969 = 100.0)



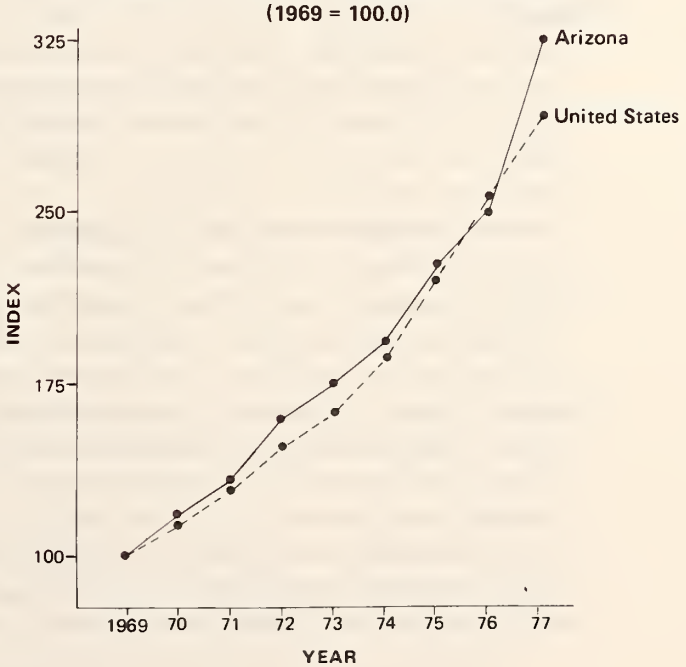
INDEX OF TOTAL HOSPITAL REVENUE PER DIEM*
(1969 = 100.0)



INDEX OF ASSETS PER BED
(1969 = 100.0)



INDEX OF HOSPITAL EXPENSE PER CAPITA
(1969 = 100.0)



*Per adjusted patient day.

Sources: U.S. Bureau of the Census
American Hospital Association, *Hospital Statistics*

rate review is presented in the section on adoption. The mechanics of the review process, the organizational structure of the program, and the current reporting requirements for institutions undergoing review are described in the content and process section; a brief outline of possible future developments that may have an impact on rate review is also included. Consumer participation in rate review and the interactions between the rate review program and other key agencies and organizations are discussed in the section on interactions. A preliminary assessment by the site visit team of the rigor, equity, and efficiency of the program is presented in the final section.

ADOPTION

The Arizona Rate Review Program was enacted in 1971. The legislation also included a Certificate of Need program and called for the development of mandatory uniform accounting and reporting systems. While the early adoption of a regulatory program for the health care system may seem to be surprising for this politically conservative state, the following review of the factors and forces that led to the enactment of the rate review program suggests that the action of the Arizona legislature in 1971 was a progressive step made in a conservative way.

In the early 1970s, the rapidly rising cost of health care was an important public issue in Arizona as in many other states. In Arizona, however, the impetus for action came from an unusual source--the business community. The story of the clash between the Phoenix divisions of the Motorola Company and the Samaritan Health Service, the state's largest supplier of hospital care, has often been told. Although the corporation and the hospital in question have long since resolved their difficulties, the issue that they agreed to discuss still is not, although it has since become more muted. Motorola executives, alarmed by the rising cost of health insurance, decided to protest a pending rate increase for the Good Samaritan Hospital in Phoenix. Their protest even took the form of newspaper advertisements essentially charging that the hospital was inefficient. The hospital made a rebuttal in similar advertisements, maintaining that outsiders could not judge the efficiency or the effectiveness of the services it provided. Eventually, the parties agreed to sit down and discuss the issue, and a solution was worked out whereby Motorola personnel were to make efficiency recommendations concerning certain hospital operations. The hospital's administration considered the services of the Motorola Company to have been helpful, but the question of whether an outside party such as an electronics company (and presumably, by extension, the government) can judge the efficiency of the hospital production process still remains unsettled within the rate review program. In any event, the well-publicized Samaritan-Motorola controversy led to legislative action.

In general, the public supported Motorola rather than the hospital during the conflict over the rates charged and their relation to hospital efficiency. This public concern led to a demand for action about rising

health care costs. As a result, a citizens' committee was formed to devise ways of coping with the problem. A legislative package, filed by Representative Burton Barr (R), was the result of the committee's deliberations. In its initial formulation, the bill called for a tough approach to controlling rising cost--specifically, the creation of a state commission with the authority to set rates and to audit hospitals, but not to monitor investments. This bill, it was said, would treat hospitals and other health care institutions as public utilities. However, the public utility approach to curtailing costs could not muster the necessary votes to pass, so a compromise was sought.

As part of the normal legislative process, a subcommittee was formed to work out a politically feasible solution. Hospital representatives were called in to determine the least painful way for their industry to be regulated. The hospitals, of course, opposed the public utility style of regulation, but they knew they could not deflect all regulatory efforts. They were told that the general public would not accept the industry's explanation for their rates. Businesses, as noted, deemed hospitals to be inefficient, and as a result, were not to be dissuaded from their desire for action.

The legislature was faced with a philosophical dilemma, namely that Arizona was and is a private enterprise state; the enactment of a tough regulatory program would clearly be the antithesis of the prevailing laissez-faire sentiment. An interesting sidelight on this philosophical issue was the behavior of the state's hospital industry during the previous two decades. During the late fifties and early sixties, mainly in response to the beginnings of marked population growth and easier access to capital, the state experienced a spate of speculative investment in hospital construction. The hospital building boom was believed to have produced an excess supply of hospital beds, which may have influenced the legislature. Actually, beds per thousand persons stood at 3.4 in 1963, rose sharply to 4.2 in 1968, and dipped back to 3.6 in 1971.

By the early seventies, it had become apparent that, despite its philosophical misgivings, the legislature would move to do something. It recognized that hospital costs were essentially not being borne by specific individuals, but in effect, by society through the third-party payment mechanism. Industry, notably the Motorola Company, had recognized that their health insurance payments were costs of doing business and so demanded action. In a state that prided itself on its attachment to laissez-faire principles and a desire to expand its business economy, a legislative response to the business sector, the key productive agent in the system, could be expected; a program to control hospital costs would probably be conceived as a program to lower the costs of doing business in the state.

Having resolved to put a program through at the risk of violating private enterprise principles, the legislature then had to grapple

with a second dilemma. This dilemma, simply stated, concerned how best to control costs in health care institutions. Key legislators understood that passing a law did not lower costs ipso facto or check rising rates. The desired objectives could be achieved only through programs and procedures that would influence the costing and pricing procedures of health care institutions. But what programs and what tools were available to do the job? At the same time, the legislators recognized that hospitals were a vital part of their communities and that their financial viability could not be jeopardized. Such were the philosophical and practical problems discussed in the deliberations of the legislative subcommittee.

Out of the discussions in committee, a single bill, House Bill 15, was developed. Once forged, the bill gained overwhelming support and passed easily. The new law differed significantly from the original bill filed by Representative Barr; the striking features of the new law included a rate review rather than a rate-setting program and embryonic uniform accounting and Certificate of Need programs. The rate review program mandated participation in the review process, but did not mandate compliance with review findings; it is for this reason that the Arizona program is characterized as a mandatory participation/voluntary compliance program.

The unique feature of the law was the coequal assignment of rate review responsibility to the state's Department of Health and the authorized local health planning agencies. At the time of enactment, the local agencies were the 314B agencies in the counties of Maricopa (Phoenix) and Pima (Tuscon) and the area health planning councils. Where no area health planning council or "B" agency existed, review functions were to be carried out by the State Health Planning Council. In subsequent years, the number and power of the local agencies, now represented by the regional HSAs, have grown, and their importance in the program has increased accordingly. Primary responsibility for program implementation has rested with the state, which has developed program regulations, forms, and procedures and has provided training and assistance to health care institutions and HSA representatives. It is fair to state that, in its beginnings, the program was to be dominated by the state, although the Phoenix area has long had an acive local agency.

Another feature of the law was the assignment of primary Certificate of Need responsibilities to the local agencies, with the state responsible for CON and permit issuance. The state cannot overrule CON decisions made by the local agencies unless the process is deemed to have been "arbitrary and capricious." Physician offices, it should be noted, were excluded from Certificate of Need review. The law also provided the Department of Health with the authority to gain access to an institution's financial records and other information necessary for carrying out its specified responsibilities. Another significant feature of the law required that the rates of the institution, after review by the Department of Health, be posted conspicuously

in the reception area of the institution. A subsequent revision, effective in 1972, established the requirement for the Department to issue a comparative study of rates and changes for all health care institutions on at least an annual basis.

A clear, unequivocal explanation for the final form of the legislation that created the rate review program and effected other changes in its health care system is not easily formulated. Political decisions are undoubtedly the result of many diverse factors, especially when the outcome is a compromise, and individuals often play a key role in the passage of legislation. In Arizona, important political, public health, and industry figures were active in the process that brought about the legislative action. And, given the politically conservative nature of the Arizona legislature, a radical change in the state's health care system was not forthcoming, as might have been predicted.

The actual changes that emerged were somewhat unexpected, and for the time, rather novel. An explanation, even if incomplete, for the final form of the legislation, including its surprising and novel aspects, would be helpful not only for increasing the level of understanding about the operation of the program, but also for understanding why the rate review program has remained essentially in its original form and has continued to receive strong political support. The basis for the changes brought about by HB 15 can be tracd to the conservative and pragmatic character of the Arizona legislature.[1]

From the perspective of a study of rate setting and rate review, the Arizona Rate Review Program is clearly of paramount importance and will be discussed subsequently. First, however, a discussion of some of the reasons behind the adoption of a Certificate of Need program may further elucidate how the rate review component of HB 15 was put together and then enacted.

The year of enactment, 1971, was a popular year for Certificate of Need legislation in other states as well. Discussions with participants in the process indicated that two factors had influenced their decision: the first was the vogue for such programs; the second was the simple fact that it made sense to exercise control over such an important component of cost if the state was also to be involved in influencing total costs by means of rate review. Thus, the Certificate of Need program was seized upon as an additional cost containment vehicle.

The program, however, was not supported by all groups; opposition from the physicians and hospitals could have been expected. The problem of physician opposition was solved by exempting the private offices and clinics of physicians, provided that patients were not kept overnight or treated under general anesthesia. The hospitals, somewhat unexpectedly, were not hostile to the Certificate of Need part of the legislation. In

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[1]It is noted that the legislature in subsequent sessions would not support a Medicaid program for Arizona, in spite of tremendous pressures to establish such a program.

retrospect, it is not implausible that the hospitals considered the program as a means to strengthen their public image as well as to protect their market position, given the assumed excess supply of beds. Equally plausible is an alternative view that a Certificate of Need program was looked upon as much less of a threat than a rate-setting commission and that the acceptance of a mildly restrictive Certificate of Need program was a prudent decision.

The rate review program has the following set of characteristics, which give it a distinctive identity. First, rate review (not rate setting) is the focus of the program; voluntary compliance, public disclosure, and local involvement are other major program characteristics. Each of these characteristics was a result of the subcommittee deliberations that eventually produced HB 15. After the decision was made to have a program with the aforementioned characteristics, the hospitals agreed to step aside and not oppose the bill. Since, as noted previously, the hospitals had been informed earlier that some degree of regulation was forthcoming, the resulting legislation could conceivably be considered to have been at least a limited victory for the health care institutions. Although such a conclusion is probably valid, since a mandatory regulatory program did not ensue, any attribution of victory to the power of the hospitals would probably be unfounded.

Factors of greater significance than the political power of the Arizona hospitals were the practical and other political issues that the legislature had to face. The fact of political conservatism in Arizona has been noted. Conservative legislatures do not rush headlong into a rigorous regulatory program in any sector of the economy; they can be expected to move cautiously. The voluntary compliance aspect of the program and the involvement of local or regional bodies in the process would seem to be the hallmarks of a legislative body intent on a cautious approach. On the other hand, the program characteristics represent a pragmatic solution to the problem of checking the rise in costs. The legislature did not believe that the tools were available for fine tuning the health care system to eliminate inefficiency, so they opted for methods that produced minimal side effects.

The primary means adopted to influence hospital behavior was the method of public disclosure of financial information. A fair and thorough review of the institutions' rates was to be carried out in as full a public view as possible. Consistent with this approach, rates were to be conspicuously posted within the institutions. Agencies at both the local and state levels were to be involved in the review process, and compliance was to be voluntary. If, after a full disclosure of its finances before the public, the institution chose not to comply with a rate review recommendation, then public pressure would be relied upon to motivate the recalcitrant institution to conform. The record of the program in terms of an institution's acquiescence to rate recommendations has been outstanding; very few providers have chosen to go against a recommended rate. At the same time, it should be noted that, as long as the institution agrees with

the rate recommendation of either the local agency or the state, it is considered to be in voluntary compliance with the program.

Nevertheless, a high compliance rate with the convergent recommendations of local and state reviewers has been a hallmark of the program. To some extent, this can be traced to the informal negotiating procedures that have evolved during the program's operation.[1] However, another part of the success of the voluntary compliance component of the program is related to the original form of the legislation. As mentioned, public disclosure and resulting public pressure were to be the means to bring institutions into line with the recommendations of rate reviewers. But, in order to exert pressure that would not be considered unfair, the review process itself had to be based on standards and procedures that would be judged as equitable. The difficulty faced by the legislature was that of designing a program that met the public's standard of fairness and would not jeopardize the financial viability of the institution under review. In the words of the law:

> Such findings shall include information on how the rates and charges relate to the operating costs and financial conditions, occupancy rates, and services provided by the institution and to rates and charges for the same or similar items or services in other institutions (House Bill 15-Article III, Section 36-450.01, lines 14 through 18 inclusive).

Thus, the legislation mandated that the reviewers examine and make public their findings on the relation between an institution's rates and its operating costs, financial conditions, utilization, and services provided. Also, reviewers had to provide information on rates and charges for similar items or services in other institutions. While the above quotation could be viewed as a preamble to a tough program to control costs, it is important to stress two points. First, the law essentially goes no further; second, the emphasis is on the provision of information and obviously is consistent with the importance of public disclosure in the rate review process. The concern for the relation of an institution's costs and financial condition to its rates and services has provided the basis for limiting the scope of rate review to a determination of the "reasonableness" of an institution's charges. Thus, the doctrine of reasonableness that has come to dominate the scope of the program, especially at the state level, is seemingly a straightforward interpretation of the intent of HB 15.

Except for any external influence imposed on the program by the HSAs through PL 93-641, the Arizona Rate Review Program has hardly deviated in the succeeding years from its concern for the financial viability of an institution, provided its rates are reasonable. In fact, this approach

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[1]The process section of this report contains a discussion of the role of informal negotiations in the rate review process.

was formalized for hospitals in 1973, when the legislature mandated that the current edition of the statement on the financial requirements of health care institutions and services, as adopted by the American Hospital Association, be used as a guide for establishing hospital rates and charges. The review agencies must now include the use of said statement as a guide for review of hospital rates and charges (ARIZONA REVISED STATUTES 36-436B). Thus, the legislature chose to strengthen the original intent of the law.

The reluctance of the Arizona legislature to adopt a more restrictive regulatory program for controlling health system costs is probably the most interesting aspect of the program's history. Certain factors seem to be of some value in explaining the static nature of the program. The political and economic power of health care institutions, particularly hospitals, should not be overlooked. Hospital trustees and staff are, quite often, influential members of the community. Also, hospitals are often major employers, especially in the smaller communities. An important Arizona-specific characteristic is the increase in the demand for hospital care that has been generated by the state's rapid population growth. As a result, the state in general is willing to finance hospitals to fill an anticipated need. Finally, to return to a familiar theme, Arizona will be unwilling to abandon its unique, broadly based program until convincing evidence is put forth for a superior alternative. The Arizona Rate Review Program is currently a popular program with a great deal of support from a wide spectrum of the total community. Although some grumbling may exist about the problem of rising health care costs in the state, there is little evidence that the Arizona legislature will lightly abandon the legislation and the resulting program that was begun in January 1972.

CONTENT AND PROCESS

Overview

The structure and processes of Arizona's rate review program differ from other prospective rate regulation programs. While the rate review program covers all health care institutions, the focus of this study will be almost exclusively on the hospital sector, which accounts for over ninety percent of all institutional patient revenues in the state.

The organizational structure of the program is somewhat complex. The rate review program is administered by the Bureau of Health Economics (BHE), a subdivision of the Arizona Department of Health Services (DHS), with final authority assigned to the director of the Department. However, the responsibility for review of proposed rate increases is also shared with Arizona's Health Systems Agencies (HSAs). This division of responsibility results in each proposed rate increase's being reviewed by a local agency (HSA) and the state agency (DHS). As noted earlier, the HSA review includes a public hearing conducted by a review panel composed of community

volunteers. The HSA governing body and BHE staff both submit recommendations on proposed rate increases to the director of the DHS. The multilevel review process involves review and analysis of each proposed rate increase by different individuals with varied backgrounds and motivations.

The timing of the rate review process is straightforward: a hospital may file for an increase at any time during the year by submitting a DHS Form 301 and supporting materials as desired to HSA and to the BHE. When the 301 form is deemed complete, the HSA must conduct a public hearing within thirty days and issue findings within forty-five days. The findings of the director must be issued within sixty days of the date of filing. Although the basic requirements for the rate review process are standard across the state, evaluation of the 301 form may differ among the various HSAs and even within the state level. The extent of quantitative analysis of the 301 form may vary depending upon the financial expertise and interests of the particular reviewer.

Because rate review recommendations do not carry the force of law, the rate review program is exempt from certain legal obligations that would apply to mandatory programs such as Certificate of Need. Specifically, rate reviewers are not required to adhere strictly to state administrative procedures; informal negotiations between providers and the review agencies are an important part of the process. The review process also allows both staff analysts and hearing panel members to question hospitals about matters not strictly within the scope of rate review, thus bringing such matters to the attention of the hospital and the public.

The following sections present a discussion of the organizational structure, timing, mechanics and scope of the rate review process, and new developments in the program. Arizona's Uniform Accounting System and other data sources available to the rate review process are also reviewed.

Organizational History of the Rate Review Program

The Arizona Rate Review Program was authorized by an Act of the Arizona legislature, House Bill 15 (HB 15), which was passed in 1971 and which also authorized a Certificate of Need program. Both programs were to commence in January 1972 and were to be applied to all health care institutions. For rate review, the structure established by the legislation has essentially been maintained, although there have been several changes in the location of the responsible agencies within the public bureaucracy of the state's health care system.

In the beginning, the rate review program was to be the joint responsibility of the Department of Health and the local agencies authorized by the Department as having the capability to perform rate review and Certificate

of Need functions--the area health planning councils (314B agencies). If no authorized local agency existed, or if the applicant was a state-operated institution, the local review was to be performed by the State Health Planning Council, the predecessor of the Statewide Health Coordinating Council (SHCC). Initially, only Maricopa and Pima Counties were able to provide the local review function through their 314B agencies. Currently, however, each of the state's five HSAs has been authorized to perform the local review.

The responsible state agency today is the Arizona Department of Health Services (DHS), the successor organization of the Department of Health. The rate review and uniform accounting programs are the responsibility of the Bureau of Health Economics (BHE), a subdivision of the Division of Health Resources of DHS. Figure 3 depicts the placement of the BHE within the organizational structure of the DHS.

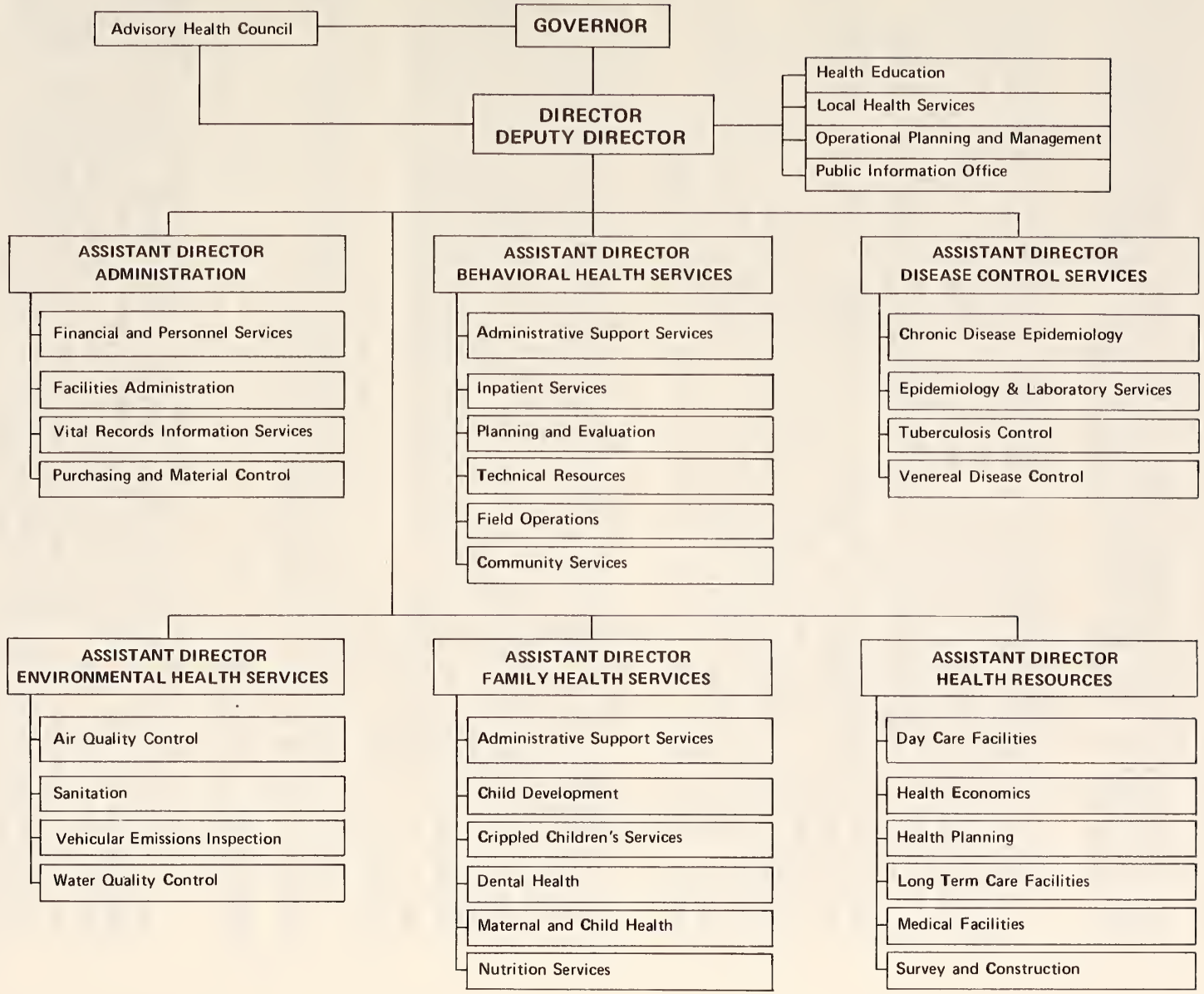
In the intervening years, the local and state agencies responsible for rate review have had several organizational sites. In 1973, the state agency responsibility was relocated from the Department of Health to the Arizona Health Planning Authority, the state 314A agency under the federal Comprehensive Health Planning Program (PL 89-749). As the result of legislation passed in 1973, the DHS was established in early 1974, assuming the functions of the previous Department of Health, the Health Planning Authority, and other health-related agencies. Accordingly, responsibility for rate review and uniform accounting was lodged in its current position within the DHS. At the local level, the passage of PL 93-641 in 1974 resulted in the current designation of the HSAs as the authorized local agencies.

Although the rate review program has been moved several times in the seven-year history of the program, this migration to and from different agencies has not been the result of legislative intent to alter the program's objectives. The movement of the state-level agency can be traced in part to general developments in health planning and to normal personality clashes, which seem to be endemic to the relation between state legislatures and the bureaucracy. The movement of the local agency can be easily related to changes in federal health planning legislation. PL 89-749 and then PL 93-641 have successively resulted in the designation of the 314B agencies, followed by the HSAs, as the authorized local agencies.

State-Level Organization

The state agency responsible for rate review is the Bureau of Health Economics (BHE) in the Division of Health Resources (DHR) of the Arizona Department of Health Services (DHS). Other bureaus comprising the DHR are the Bureau of Health Planning, the Bureau of Survey and Construction (state responsibility for Certificate of Need and construction permits), and three

Figure 3
ARIZONA DEPARTMENT OF HEALTH SERVICES



certification/licensing bureaus (medical facilities, long-term care, and child day care). DHS has recently lost its conditional designation as the State Health Planning and Development Agency (SHPDA).

The major responsibilities of the BHE are the rate review and uniform accounting programs. In addition, BHE staff conduct financial feasibility and health economics studies. Related activities include publishing annual reports, monthly and annual summaries of rate review activity, and a semiannual comparative study of rates and charges of all health care institutions. BHE staff also provide technical assistance to the HSA staffs and review panels as necessary. As the HSA staffs are selected and gain experience, however, the level of this support declines. BHE activities are supervised by the Bureau chief. The rate review staff consists of two analysts and a statistical clerk. The uniform accounting staff has a program manager, a research and statistical analyst, and a statistical clerk. There is also a Bureau secretary. All positions are state funded except one uniform accounting position, which is SHPDA funded.

This is a rather limited staff for the task of reviewing proposed rate increases for seventy-two hospitals, eighty-three nursing care institutions, and certain other health care institutions. During 1978, the staff processed 193 filings for new rates and rate increases, with incremental revenues amounting to $11 million for new services and $76 million for rate increases. The current revenue base is approximately $700 million for hospitals and $70 million for nursing care institutions. The BHE budget for fiscal year 1979 is $153,000, about sixty percent of which is allocated to rate review.

BHE staff participate in all rate reviews; however, the depth of their analysis varies with the complexity of the filing.

HSA-Level Organization

Arizona has five HSAs, two of which are fully designated by DHEW and three of which are conditionally designated. Four of the HSAs have been designated by DHS as "authorized local agencies" for the purpose of rate review and Certificate of Need activities. For the HSA not authorized and for all state-operated institutions, the local review function is performed by the Statewide Health Coordinating Council (SHCC), which uses its Health Economics Committee as the review panel.

The four authorized HSAs each have at least one part-time analyst performing rate review staff support. They must also have a review panel, commonly called "Rate Review Committee," which operates under the jurisdiction of the HSA's governing body.[1] This panel is comprised of community volunteers,

[1]The role of the review panel in the rate review process will be discussed in detail in the section on interactions among the components of the state's health care system.

representing both consumer and provider interests, and is responsible for conducting public hearings on proposed rate increases. The review panel, following a public hearing, develops its findings and recommendations concerning the proposed increase. These findings must be ratified by the HSA's governing body, which then submits a recommendation on the proposed increase to the director of the DHS.

The rate review staffing levels for the state's HSAs are as follows:

HSA #1	Central Arizona[1]	- 1 secretary, 2 full-time analysts
HSA #2	Southeastern Arizona[1]	- 1 full-time analyst
HSA #3	Northern Arizona[1]	- 1 part-time analyst[2]
HSA #4	Navajo Nation	- no assigned staff
HSA #5	Western Arizona[1]	- 1 part-time analyst[2]

Timing and Procedure

Institutions may file for a rate increase at any time, and although it is frowned upon by the review agencies, they may file for multiple increases during the same fiscal year. The fact that they can refile if they find themselves in trouble is a palliative that frequently motivates applicants to adopt recommended reductions in proposed rate increases. The two peak filing periods are October and April, which are sixty days preceding the rate increase dates (January 1 and July 1, respectively).

All rate increase filings must include operating and financial information over a three-year period--specifically, the "prior year," the "base year," and the "projected year." The projected year represents the budgeted year, or the year in which the rate increase is to be implemented. The base year and prior year are the first and second years before the projected year, respectively. The review period is sixty days, so an institution must file at least sixty days in advance of a planned rate increase. Institutions are encouraged to file in advance of the projected year, reporting both budgeted revenues and expenses for the full year. However, regulations allow an institution to file up to six months into the budgeted year and still use that year as the projected year. For example, if an institution's budgeted year is calendar 1979, it could file at any time from July 1, 1978 through June 30, 1979, using 1979 as the projected year. The preferred and customary practice, however, is to file on or before October

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[1]Authorized local agency.

[2]Analyst devotes half of his time to rate review and the other half to Certificate of Need.

31, 1978, allowing a sixty-day review cycle for a rate increase to become effective January 1, 1979. A hospital may decrease rates exclusive of the review process, providing advance notification is given to the BHE.

To initiate the review process, the hospital must submit a properly prepared DHS Form 301, "Financial Report for Review of Proposed Rate Increases - Hospitals," to the local HSA and to the BHE. Supplementary materials, such as an annual report or a description of a cost containment program, may be included with form 301 to provide additional justification for the rate increase, or to demonstrate management effectiveness. The law also requires hospitals to submit an annual certified financial report within four months after year-end closing. Information from these reports is frequently utilized in the review analysis. When the 301 form and supplementary materials, commonly referred to as a filing package, have been received by the two agencies, the first step of the review cycle, the determination of completeness, begins. The HSA and the BHE must jointly determine whether the 301 form is complete; i.e., whether all required information has been included. Although the 301 form is designed to provide the basic information for the review process, the review agencies may request supplemental schedules as necessary to support the information presented. A schedule of all changes in rates and charges resulting from the rate increase must be included as part of the 301 form. The BHE has a checklist of requirements, the "Rate Review Package Checklist for Completeness," used by BHE staff and several of the HSAs. When both agencies agree that a filing package is complete, the filing date is established and the sixty-day review cycle begins.

The HSA must hold a public hearing on the proposed rate increase within thirty days of the filing date. Prior to the public hearing, HSA staff conduct their analysis of the proposed increase and prepare summary information and pertinent questions about the 301 form for the review panel. Notice of the public hearing, along with the observations and questions generated by the HSA staff, must be forwarded to the applicant at least ten days prior to the public hearing. As soon as possible within the cycle, the HSA selects the review panel from its rate review committee and provides the panel with copies of the filing packet, observations and questions, and other pertinent information.

The next step in the process is the public hearing. The hearing is opened by the panel chairman, who customarily reads a prepared statement summarizing the reason and authority for the meeting and the process to be followed. The usual procedure at the hearing is for the hospital team--usually composed of the administrator, the financial manager, and other key personnel--to make an initial presentation on the status of operations, reasons for the proposed rate increase, and responses to the HSA's observations and questions. It is desirable that the presentation also include statements on problems faced by the hospital, planned expansion of capacity

or significant capital equipment, cost containment programs, budgetary assumptions used, etc.

Upon completion of the applicant's presentation, each member of the review panel asks questions or makes comments relative to justification of the increase or other management issues. Following the panel's questions and responses by the applicant, the public is invited to ask questions or make comments. Although not a formal participant in the hearing, an HSA staff analyst is available to the panel as a resource person. Usually BHE staff are also in attendance, primarily for the purposes of receiving the information presented and learning about the issues involved.

After deliberation, the panel announces its findings. It can endorse the increase in part or in full or recommend denial in full, and should provide a rationale for its recommendations.

The findings of the panel are then summarized by HSA staff and placed on the agenda for review and ratification by the HSA's governing body. At the meeting of the governing body, the panel chairman presents information on the review and the panel's findings. The applicant may also make a presentation at this time if it is felt that the panel's findings were not equitable. The governing body will then declare its position, which will be to either ratify the panel's findings as submitted or to modify them as deemed appropriate. Documentation of this action, along with other pertinent information, is prepared by HSA staff.

The HSA's findings are then forwarded to the director of the DHS, and customarily, to the applicant. One criticism of the review process is that HSA governing body members usually have not previously participated in the review, and thus their decision may be based on insufficient information or irrelevant political factors.

Concurrently with the HSA review, the BHE (DHS) performs a virtually independent analysis of the proposed increase. The initial step in this analysis is the preparation of summary review statistics. Within timing and scheduling constraints, a copy of this information is provided to the HSA for use in their analysis according to their discretion; the summary statistics are used by HSA staff and panel members in most of the HSAs.

As previously noted, a BHE analyst usually attends the public hearing and other meetings between the HSA and the applicant to maintain continuity and be fully informed of the issues involved. Since the DHS findings must be issued within sixty days from the date of filing, and since formal HSA findings are frequently not received until late in this cycle, the BHE analysis must necessarily proceed in advance of final HSA findings, but BHE staff, of course, consider the HSA's concerns and findings in their analysis and deliberation over rate adoption. By law, the BHE may, at its discretion,

make an independent review of the rate increase. Thus, BHE is able to request and receive supplemental information from the applicant and to conduct its study in tandem with the HSA's study. In practice, the request for additional information occurs only in controversial cases. Regulations specify, however, that the applicant may not introduce information that would change the base or projected year's revenue or expense levels by more than 0.5 percent of the original submittal without initiating a new filing and sixty-day review period.

On completion of its review, the BHE prepares its findings, basically within a standardized format. These findings may fully support the HSA's position, may suggest adoption with exceptions or with supplemental findings, or may contradict the HSA's findings. In consideration of the resources applied by the HSA, many of which are voluntary, and the relationships between the local and state agencies, every effort is made to reconcile basic differences. Of course, the state's position is much stronger if the review agencies offer consistent recommendations.

Under current practice, if the BHE recommendation is different from the HSA's, the BHE will arrange a public meeting to review the situation. Such meetings are conducted by the Health Economics Committee (HEC) of the Statewide Health Coordinating Council (SHCC) in its capacity as an advisory body to DHS. Attendance at the meeting includes representatives from BHE, the HSA, the applicant institution, the Health Economics Committee, the Director's Office (DHS), and the public. Presentations are usually made by the HSA, the BHE, the applicant, and others as each desires. The purpose of the meeting is to air the issues involved and to provide the director with the facts on which a decision may be reached. The HEC meeting, which in essence provides the institution with an additional public meeting, acts as an informal appeals mechanism; meetings of the HEC have been infrequent. Since agency rate review recommendations do not have the force of law, there is no formal appeals mechanism.

When the BHE staff have completed their review, the BHE recommendation is issued to the Director's Office. The BHE findings incorporate the HSA findings. Approval of state and HSA rate review findings is delegated by the director to the assistant director in charge of the Division of Health Resources, who must issue DHS findings within sixty days of the beginning of the review cycle. In the majority of cases, BHE and HSA recommendations concur and are endorsed by the state. For example, in calendar 1978, out of 171 rate filings processed, the state disgreed with the HSA in four cases, representing a total difference in incremental revenue of only $392,000. Coincidentally, the four cases were all nursing care institutions. The assistant director does have the options of issuing new and separate findings or endorsing one of the two recommendations if there is a disagreement.

The applicant is legally entitled to implement the rate increase upon issuance of the state findings, or sixty days from date of filing, whichever occurs first. In the event that the findings recommend reduction in part or in full of the proposed increase, the BHE, preferably with HSA participation, will attempt to "sell" the hospital on adopting the recommended level of increase. If the DHS findings differ from the HSA recommendation, the hospital is considered to be in compliance if it adopts either of the two recommendations.

Figure 4 depicts the procedural steps and timing of the rate review process.

Informal Negotiations

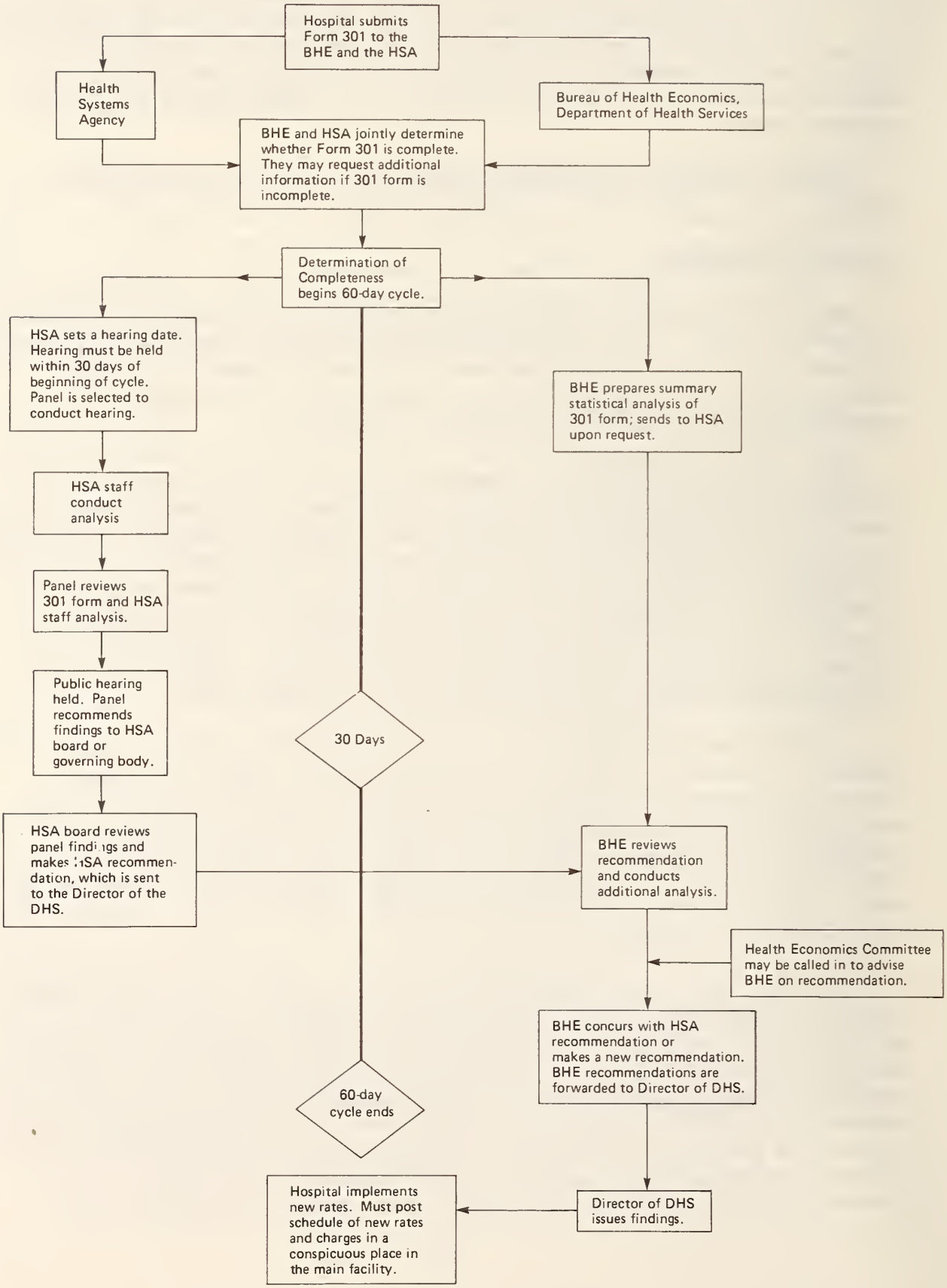
An apparent benefit of the voluntary compliance system is the freedom to conduct reviews that are not governed by state administrative procedures. Informal negotiations and discussions are an integral part of the rate review process. Negotiations may take place prior to determination of completeness and throughout the sixty-day review cycle.

The joint determination of completeness of a filing package by BHE and HSA staff is the only point in the process where rate reviewers can legally affect the outcome of a rate review. Staff can delay the beginning of a review cycle by declaring a filing package to be incomplete and requesting additional information or by rejecting the filing package, making it necessary for the hospital to refile its application. Due to problems involved in applying standard criteria and in reaching agreement between the two review agencies, consideration is being given to making BHE the sole agency responsible for determination of completeness.

In practice, long delays rarely occur. Often if a package is incomplete, the analyst will set the hearing date and request additional information during the interim. Discussions between hospitals and staff concerning the filing packages are not uncommon. Staff analysts may request clarification of certain items and may also suggest methods for more clearly presenting financial information. Informally, the hospital staff "get the message" about potential deficiencies in their justification of the proposed increase.

The next major negotiation opportunity occurs at the public hearing. The public hearing is without doubt the most significant part of the process in that it motivates the hospital to demonstrate effective management and financial control. Hospital managers can elaborate on written material to the satisfaction of the panel conducting the hearing, and panel members may question managers about management practices, and discuss alternative methods. Such exchange of information with the community has frequently led to direct benefits for the hospital. For example, the process has led to voluntary assistance from community organizations in

Figure 4
PROCESS AND TIMING OF RATE REVIEW IN ARIZONA


Hospital submits Form 301 to the BHE and the HSA
Health Systems Agency
Bureau of Health Economics, Department of Health Services
BHE and HSA jointly determine whether Form 301 is complete. They may request additional information if 301 form is incomplete.
Determination of Completeness begins 60-day cycle.
HSA sets a hearing date. Hearing must be held within 30 days of beginning of cycle. Panel is selected to conduct hearing.
BHE prepares summary statistical analysis of 301 form; sends to HSA upon request.
HSA staff conduct analysis
Panel reviews 301 form and HSA staff analysis.
Public hearing held. Panel recommends findings to HSA board or governing body.
30 Days
HSA board reviews panel findings and makes HSA recommendation, which is sent to the Director of the DHS.
BHE reviews recommendation and conducts additional analysis.
Health Economics Committee may be called in to advise BHE on recommendation.
BHE concurs with HSA recommendation or makes a new recommendation. BHE recommendations are forwarded to Director of DHS.
60-day cycle ends
Director of DHS issues findings.
Hospital implements new rates. Must post schedule of new rates and charges in a conspicuous place in the main facility.

areas such as risk insurance, financing, and data processing. In the Central Arizona HSA (CAHSA), a panel member with a business background was instrumental in persuading a hospital to change to a better computer system.

If hospital managers disagree with the findings of the panel, they may approach the HSA board. The HSA board or governing body may on occasion refer the panel's findings back to the hearing panel for further deliberation if the board members take exception to some element of the panel's recommendation or findings.

The next point of negotiation occurs during the BHE review following the HSA recommendation. If a hospital's management disagrees with the HSA's recommendation, hospital staff may informally discuss the recommendation with BHE staff and submit additional materials to justify the proposed rate increase. As stated previously, a hospital cannot submit information that would change the reported revenues and expenses for the base or projected years by more than 0.5 percent. The hospital may, however, present additional or more up-to-date information to substantiate its case. A hospital may also wish to demonstrate the negative effect that the HSA's recommendation, if adopted, would have on its operations. In addition, there may be controversy over whether certain items are appropriate for rate determination purposes. In such cases, BHE may call another public hearing, using the Health Economics Committee as a hearing panel. The Health Economics Committee does not normally offer a decision on the rate increase, but rather, acts in an advisory capacity to DHS. The BHE may also concur with an HSA recommendation, but at the same time, call public attention to certain hospital practices and rely on public pressure to remedy the situation.[1]

The final negotiations occur if and when the findings, as issued by the director, recommend reduction in the level of the proposed increase. In such cases, BHE and HSA representatives meet with the applicant to review the established position and to try to convince the applicant that the findings are equitable and that the applicant should adopt them. Occasionally, members of the HEC, such as the Blue Cross representative, participate in these discussions.

Scope of Rate Review

The state and local recommendations on a proposed rate increase are based primarily on an analysis and review of the filing package submitted by a hospital.[2] Each institution's proposed rate increase is evaluated on the basis of the information contained in the 301 form and the hospital's internal financial requirements. In addition, comparisons are made with

[1]BHE staff once succeeded in persuading a hospital to "voluntarily" close down an underutilized obstetrics unit using this tactic.

[2]The filing package consists of the completed Form 301 and any supplemental materials that the institution may decide to include. Form 301 is described in detail in the next section.

comparable institutions in areas such as rates and charges, statistics per patient day, and financial ratio analysis.

According to statute, the state recommendation issued by the director of the DHS must include information on the following:

- how the rates and charges relate to the operating income and expenses of the institution, and

- the source and application of funds available to the institution (Arizona Statutes, Section 36-436(c)).

There is no specified content or format for HSA findings, but most of the HSAs use a standardized format developed by the BHE. Hospitals must use the American Hospital Association's "statement on the financial requirements of health care institutions and services" as a guide for establishing rates and charges, and the director must use the AHA statement as a guide for reviewing proposed rate increases for hospitals (Arizona Statutes, Section 36-436 (B)). Although the principles in the AHA statement are followed, it is too general a document for detailed rate analysis. For example, the forty-page statement, as issued February 12, 1969, was superseded in 1977 with a document of only two pages!

There are no statewide guidelines for evaluating a proposed rate increase. It is the task of rate reviewers to determine whether a proposed rate increase is "reasonable" given the relevant quantitative and qualitative information about the hospital under review. Proposed increases may be assessed differently by different review bodies; for example, the BHE and an HSA may not agree on the appropriate amount of increase. Additionally, in their evaluation of a proposed increase, different analysts and different individuals on a hearing panel may emphasize different concerns.

Quantitative Analysis

There is no established methodology for conducting a quantitative analysis of the 301 form that is applied consistently by the review agencies. The emphasis placed on particular sections of the 301 form can vary with the locus of review and the expertise of the reviewer (i.e., BHE or HSA staff versus a volunteer panel member).

It should be noted that, while there is no standardized methodology for reviewing 301 forms, all hospitals are exposed to diversified analysis since all filing packages are reviewed by analysts or groups in multiple locations. However, many aspects of quantitative analysis of the 301 forms are common to all loci of review. Typical elements of the quantitative analysis include the following steps:

- examine hospital's long-range plans;
- determine if profit level is reasonable (e.g., within four to seven percent of gross patient revenue for nonprofit hospitals);
- compare past budget projections to actual amounts spent;
- study trends in revenues and expenses for three-year period;
- examine debt service coverage;
- review financing of proposed capital acquisitions;
- compare utilization relative to capacity;
- check relationship between increase in revenues and increase in volume and prices;
- compare selected rates with those of similar institutions;
- look at trends in patient mix, length of stay, and admissions for three-year period; and
- consider age of physical plant in assessing financial requirements.

Not all of these elements are examined by all reviewers. Other general analytic procedures are discussed below.

Summary Statistical Report

A BHE statistician routinely prepares a summary statistical report derived from information on the 301 form, which is described in the section on data requirements. In addition, the summary report contains a comparison of selected proposed rates of the hospital under review with a sample of five or six similar hospitals. Interhospital comparison is a minor component of the review process and is used primarily to detect gross differences in patient day revenues and expenses between similar institutions. The summary reports are usually forwarded to the HSA for use at their discretion.

Trend Analysis

The institution-specific budget review process essentially precludes trend analyses across institutions. However, intrahospital trend analysis

is an important feature of the Arizona review process. Trends over the past, base, and projected budget years may be examined for some or all of the following indicators of hospital activity:

- salaries and wages;
- patient days;
- gross revenues;
- direct expenses for revenue-producing and non-revenue-producing departments;
- deductions from revenues;
- changes in patient mix (third party, private payors, etc.);
- length of stay; and
- admissions.

An examination of intrahospital trends is a standard review procedure, but the intensity of its application varies. The general procedure is to look for explanations for above-average changes in these variables. Large hospitals are generally scrutinized more carefully than smaller hospitals.

Other Review Criteria

The two review groups may have concerns that indirectly influence their recommendations. In Arizona's rate review system, "hidden agendas" which may motivate review committee members or analysts have a potential influence on the outcome of the review process. HSA analysts stress the hospital's long-range plans and cost containment programs. Any cooperative, cost-saving arrangements made with other hospitals within the HSA, such as the sharing of a kidney dialysis unit, are considered points in the hospital's favor. These concerns are often shared by consumers on the HSA's rate review committee who also serve on the public hearing panels.

Panel members may have additional concerns resulting from their professional or consumer perspectives. Committee members from private industry tend to view good financial management and planning as crucial to the control of cost inflation, and may look favorably upon institutions that demonstrate innovative management and planning techniques. Other committee members attribute great importance to the impact of financial decisions on quality of care and on the local community. An increase in pharmacy prices, for example, might be viewed unfavorably because of a

possible impact on people with fixed incomes. Members of the community served by the hospital under review may express similar concerns at the public hearing. Thus, the recommendation of the public hearing panel and the HSA board may on occasion reflect concerns outside the scope of rate review.

HSA staff and panel members may also share a concern over quality of care and accessibility, particularly in HSAs serving rural areas. Access to good quality medical care is a priority in the large and sparsely populated areas in the northern and western parts of the state. HSA analysts, the hearing panel and the HSA board might all consider a high rate increase for an underutilized institution warranted if the rate increase permits a small rural hospital to continue in operation. If a rural institution were forced to close, a certain area's access to medical care would be severely curtailed, which would affect health care delivery in one or more communities. Such a recommendation probably extends beyond the scope of rate review because the findings are not based solely on the information contained in the 301 form, but it is nonetheless appropriate to consider such issues during the rate review process.

BHE analysts may bring yet another perspective to the process. The BHE may have statewide planning concerns against which it assesses proposed increases. The HSA's perspective on access issues might well be shared by the BHE staff; they also favor enabling small rural hospitals to remain open. In other instances, the state perspective may differ. An HSA, for example, may recommend only a small rate increase for an institution on the basis that such an institution should not be allowed to charge higher rates for poor quality care. The BHE might issue a different recommendation, arguing that a large increase is warranted by a consideration of the institution's financial requirements; a large increase would indirectly affect quality of care by enabling the institution to make improvements. Thus, the BHE does not always avoid quality of care and access issues, although it does give primary consideration to the institution's financial requirements.[1]

The BHE staff, again in keeping with its statewide responsibilities, views the maintenance of good relations with the hospital industry to be of paramount importance for the successful functioning of the voluntary compliance system. State-level staff may have a greater concern than HSA staff over the risks of alienating particular institutions or the industry as a whole. HSAs receive both state and federal funding, but the BHE is dependent on the continuing support of the state legislature, and indirectly, of the hospital industry to ensure the continuation of the rate review program.

Because there are no formal and consistent review criteria for making recommendations on proposed rates, considerable discretion is

[1]Quality of care is more likely to be an issue in nursing home rate review than in hospital review.

exercised by rate reviewers as to what constitutes a "reasonable" rate increase. Knowledge about the past behavior of particular providers, gained over several years' experience with rate review, can be a valuable supplement to a quantitative analysis of a 301 form. An awareness that an institution seeking a rate increase has overprojected past budgets by a wide margin, for example, could influence a panel member's recommendation. The ability of staff and committee members to make informed judgments about providers, based on a knowledge of Arizona's health care system and/or extensive experience with rate review, is an important asset to the program, and the continuity of staff and committee members has greatly facilitated "individualized" review.

Data Requirements

The financial and other data necessary for the rate review process are to be contained in DHS Form 301. Additional information may also be provided by the institution under review. The core statistical data required include Balance Sheet Information (Section B), Revenues and Expenses (Section C), a Departmental Cost-Finding Statement (Section E), and a Schedule of Rate Changes.[1] Some of the core statistics are summarized in an introductory summary Section A. Included in the summary part of the form are a Statement of Need for Increased Rates and a Financial and Statistical Summary.

The Statement of Need for Increased Rates calls for the presentation of both quantitative and qualitative information. A requested overall percentage increase in rates must be indicated. This overall rate is expressed as a percentage change in annualized gross patient revenue from existing to proposed rates and charges. In addition, statements explaining the reason(s) for the rate increase and the pricing policy of the hospital are to be included.

The financial summary of Section A consists of three parts. The first is a listing of Patient Revenues, Deductions from Patient Revenues, and other Revenues and Expenses, along with a resultant net surplus or deficit. The above financial information is presented for three yearly time periods--the projected year, a base year, and the prior year. There are two variations of the yearly time periods, corresponding to whether the applicant files during the first six months or the last six months of the year. If the 301 form is filed during the first six months, the base year is the previous year and the projected year is the current year. In this case, data are projected for only the remaining portion of the current year. If the 301 form is filed during the last six months of the year, the base

[1]Charges for items received from an outside supplier, such as pharmacy or central supply items, may be listed on the schedule of rate changes in the form of a formula outlined in statute R9-11-114. This is the only formulary aspect of the 301 form.

year is the current year and the projected year is the subsequent year. In this case, data are projected for the remaining portion of the current year and the entire subsequent year. Thus, the actual amount of time for which data are projected can vary, depending on the time of filing, from six to eighteen months. For any filing, one of three revenue data sets can be presented. The first version calculates the revenue data for the projected year at the existing rates. The second, used only if the increase is implemented during the year, calculates the year's revenue on the basis of existing rates for part of the year and proposed rates for the balance of the year. The third version calculates the revenue on the basis of proposed rates annualized. Of course, if the increase is to be implemented at the start of the fiscal year, annualization is not required.

The second component of the financial summary is a schedule that documents the anticipated changes from the base year to the projected year (annualized). The essence of the schedule is to display an allocation of the revenue increase between changes due to volume and changes due to price. The allocation can be explained symbolically:

Let P_o = price in base year

P_1 = price in projected (annualized) year

Q_o = output in base year

Q_1 = output in projected year

then

$P_o Q_o$ = patient revenue in base year

$P_1 Q_1$ = patient revenue in projected year

and $P_1 Q_1 - P_o Q_o = R$ = change in patient revenue

and $P_1 Q_1 - P_o Q_1$ = change in patient revenue due to price

and $R - (P_1 Q_1 - P_o Q_1)$ = change in patient revenue due to volume

In words, the projected output is priced at the existing and proposed (higher) prices, and the difference between the two revenue totals represents the percentage rate increase (due to price factors). This change

due to price is then subtracted from the change in patient revenue to obtain, as a residual, the change due to volume.[1] A similar calculation is carried out for expenses, and changes in revenues and expenses are compared for reasonableness. A net change of zero implies a continuation of the status quo for the institution. Thus, if a hospital were in a sound financial position prior to the submission of its rate review package for the projected year, then a rate increase sufficient to cover added expenses would, in effect, ensure its financial viability for another year.

The third and final part of the financial summary is a comparative analysis of base-year and projected-year expenses by cost categories such as salaries and wages, other expenses, and depreciation and interest. Changes in the expense accounts between the two time periods are presented in absolute and relative amounts. Again, the anticipated changes in the expense categories are allocated between a price and a volume factor.

As noted, summary statistical data are also to be provided in the introductory section of the form. The following statistics are to be supplied for a three-year comparison (covering the prior, base, and projected years):

- inpatient days (medical/surgical, acute care, obstetrics, etc.);
- admissions;
- outpatient visits;
- emergency room visits;
- average length of stay;
- occupancy rate;
- beds available; and
- licensed beds.

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[1]Purists might object to a two-part division of the change in patient revenue, for actually, there are three parts to such a division, as follows:

(1) a change due to price, or $(P_1 - P_0)Q_0$

(2) a change due to volume, or $(Q_1 - Q_0)P_0$

(3) a change due to changes in both price and volume, or $(P_1 - P_0)(Q_1 - Q_0)$

The formulation in form 301 attributes the third part above to price changes alone.

Additional statistical data such as gross and net patient revenue, cost per patient day, and net revenue per patient day, along with accounting data such as the working capital ratios, are listed for the three years. Also, employment (FTEs), in total and by department, is also reported for the yearly periods. Also, for the base year, information on patient days by type of payor is included. The last inclusion in the introductory summary section is a statement on the hospital's sources and uses of funds for the three year-long periods.

Balance Sheet Information is to be presented in Section B of the form. Several important schedules for the base and prior years are required along with the balance sheet of the institution, including Additions to Property, Plant and Equipment, and Acquisitions through Leasing for the projected year. The capital acquisition statements, it should be noted, do not include reference to Certificate of Need requirements or status.

The succeeding section presents departmental revenue and gross data for the three years. Gross patient revenue by nursing and room services, which includes acute care and medical/surgical units, and by other professional services, such as the operating and recovery room and the radiology department, are to be listed. Deductions from gross patient revenue are to be included in order to obtain net patient revenues. These deductions include Medicare discounts, uncollectible accounts, and charity. Summary expense data are then listed for the patient service departments, the general service and administrative departments, and the fiscal service departments. Also, under the expense classification, depreciation and interest costs are to be included. The total expenses are deducted from net patient revenues to determine the surplus (deficit) derived from operations. Revenue from other than operations, such as cafeteria sales and rentals on physicians' offices, are then added to yield a final net revenue figure. All of the detailed revenue and expense data by departments for the projected year are to be apportioned to either changes due to price or changes due to volume.

The next section of the form (Section D) is a summary of changes in revenues and expenses for the base and projected years. Again, the changes are to be divided into price and volume effects. Net patient revenues are given in summary form for the nursing and other professional service departments. What is new information in this section is that on salaries and wages and other expense data for the patient service departments, the general service department, and the fiscal and administrative service departments. Depreciation and interest expense data are to be included unless these costs have already been allocated to departmental cost centers. The inclusion of other revenues allows for the calculation of a net revenue surplus or deficit for the institution.

Section E contains cost-finding statements for the base year. These statements present data on gross revenue, deductions, salary and wage expense, other direct expense, indirect expense, and net revenue for the revenue-producing patient service departments. The information is to be given for each of the components of the patient service departments. For example, under nursing and room services, data on the acute care, pediatric, medical/surgical, etc., are to be included. Under the other professional services, data on each of its departments such as radiology, pharmacy, and emergency services are to be provided.

The last section is to contain schedules of rate changes for the services provided by the institution. The schedules are to list the service provided, the implementation date of the existing rate, the existing rate, the proposed rate, and the percentage change in rate.

If the hospital files its form 301 after the beginning of its current fiscal year, it must submit a financial report containing year-to-date (YTD) information for the current fiscal year as well as the prior year. It may either use a "Hospital Financial and Statistical Operating Report," DHS Form 201, or an internal Interim Financial Report. The purpose of this report is to provide YTD information for the time period since the hospital last filed an annual financial report using the Uniform Accounting System.

As part of the rate review process, the BHE staff prepares a summary statistical sheet based on the 301 form submitted by the hospital. The sheet, an Analysis of Proposed Revenue Increase, is a summary and distillation of the information contained in form 301, plus comparable data where relevant from a sample of similar hospitals. The sample hospitals are usually selected from the hospital peer groups created for the Uniform Accounting Program. Other considerations in sample selection are geographical proximity, age of physical plant, special services, bed size, and population served. The analysts who customarily choose the sample rely partially on longstanding familiarity with the state hospitals in making their selection. Thus, the data on trends for the particular hospital under review and data on the average values for a grouping of similar hospitals are made available in a single, compact report. Information presented includes:

- comparison of rates and charges for selected services with those of comparable institutions;
- summary of operating and financial statistics for the three-year reporting period;

- trend of statistics per patient day and comparison with comparable institutions;

- detail of expense increases from the base to projected year, broken down between volume and price factors;

- source and application of funds over the three-year period, with the projected year a pro forma analysis on the basis of both existing and proposed rates; and

- other information as deemed relevant.

In summary, form 301 and its derivative, the statistical summary report, provide the basis for the quantitative part of the rate review process in Arizona.

Uniform Accounting

Hospitals are currently required to submit to the BHE annual operating statements and reports conforming to the reporting requirements of the "Hospital Accounting and Reporting Manual."[1] The annual report must be submitted not later than 120 days after the end of the hospital's fiscal year. The Manual establishes uniform accounting practices to be adopted by all hospitals in reporting financial and statistical data to the BHE, which will eventually enable the BHE to compile a comprehensive data base of financial and statistical data for Arizona's health care institutions.

Prior to the implementation of uniform accounting, hospitals were required to file an annual package of operating statements and reports to the BHE. This package included the DHS Form 201--"Hospital Financial and Statistical Operating Report." The 201 form is still used as part of the rate review filing package for reporting, at the time of filing, year-to-date (YTD) information since the last annual uniform accounting report was submitted. Though these annual reports provided a useful source of data on individual institutions, compilation of aggregate statistics across hospitals was difficult because of the variations in reporting practices; uniform accounting requirements will greatly facilitate this process.

Hospitals have been required to use the uniform accounting system for FYs beginning on or after July 1, 1976.[2] BHE staff have one year of hospital data (1977) and are currently receiving reports for the second year (1978). When all the reports for 1978 are submitted, the BHE will

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[1]Arizona regulations, Chapter 11, Article 2, R9-11-211 (B).

[2]Ibid.

have two full years of data and can begin to construct the data base. The amount of statistical data generated by the BHE will increase substantially after the new data base has been compiled.

The uniform accounting system was implemented primarily to provide uniform data to the public and to assist the BHE in the preparation of health economics and financial feasibility studies. However, uniform accounting and rate review are linked in several ways. One component of the uniform accounting program was the creation and utilization of a peer grouping methodology, which was devised to facilitate interhospital comparisons[1] in the state. Under the peer grouping system, Arizona's seventy-two hospitals are clustered into twelve groups, four of which represent specialty and mining company hospitals. The clusters are formed using eleven variables for each institution. The resultant groupings of hospitals are generally used by BHE rate review staff in preparing the summary statistical report (see Appendix A) from form 301. The report, as noted, lists selected average rates from a sample group of five or six hospitals similar to the hospital under review.

Future implications of the uniform accounting program for rate review will be discussed subsequently. Briefly, despite the lack of trend data in the uniform accounting annual reports, the existence of uniform aggregate data will probably increase rate reviewers' use of interhospital comparisons. The uniform accounting program will prepare annual reports, which will contain comparisons of each hospital against its peer group, as well as aggregate peer group data and extensive aggregate data for all hospitals. All of these data will be computerized and made available in printout form.

Availability of Data

There are four basic sources of hospital data presently available from the Bureau of Health Economics:

- DHS form 301 submitted by hospitals;[2]
- uniform accounting annual reports and audited financial statements;
- monthly and annual rate review activity reports; and
- annual comparative studies of selected rates and charges for all institutions.

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[1]Arizona's peer grouping methodology is similar to and partially based on the peer grouping system for the State of Washington (see Abt Associates Inc., "A Case Study of Prospective Reimbursement in Washington" (AAIND-79-4(1)); HEW Contract No. 500-78-0036, November 1979).

[2]Form 301 data are not available for all hospitals for all years.

The first annual report of the Uniform Accounting Program, containing 1977 data, will be released shortly. These data, which are computerized, will include a substantial amount of aggregate hospital data statewide and by peer group, and will also contain intrapeer group comparisons. Data pertaining to the review process are available in the monthly and annual Rate Review Activity reports. The monthly reports contain tables of rate increases implemented in the year to date; the annual reports contain rate increases implemented during the entire year. In the annual report, hospitals are listed by county and are described by seven data items: hospital type (government, nonprofit, or proprietary), number of beds, date of state findings, and--under the category of "projected revenues annualized"--base-year rates, new rates, amount of increase, and percentage of increase. Total base-year rates, total new rates, and total percent increase are listed in the annual Rate Review Activity report by county and by total state, with the latter broken down by type of hospital. (Sample pages of the annual Rate Review Activity reports are included as Appendix B. Additional information about the activities of the Bureau is available in the BHE annual reports.)

A fourth source of data is the semiannual comparative studies of selected rates and charges for all institutions, published by the BHE. The latest study, based on charges in effect January 1, 1979, presents comparative charges for twenty-one hospital service categories. Hospitals are divided into subcategories by bed size and geographic region. An unweighted mean is listed for each service by subcategory and ranges are given by geographic region. Also, means and ranges for each service are given for total state hospitals. It is stressed in the study that some of the rates and charges may not be fully comparable. (The January 1979 Comparative Study of Rates and Charges is included as Appendix C.)

What appears to a researcher as a paucity of data probably is due to several factors. Most importantly, collecting aggregate hospital data is not seen as a high priority. Each hospital is reviewed on an individual basis: earlier 301 forms are available for historical comparisons, and summary statistics prepared for each 301 form include a comparison on selected rates with other institutions. Since proposed hospital rates are not reviewed on a group basis, there is little need, for example, for a printout breaking down costs by payor for all Arizona hospitals. There are also the limitations of budget and personnel to be considered; the BHE has neither staff time nor funding to improve its data base.

New Developments

Uniform Accounting System

Since July 1976, hospitals have been required to submit an annual financial report to the BHE, using the uniform reporting requirements outlined in the Hospital Accounting and Reporting Manual. The

implementation of a uniform accounting system for hospital reporting has some implications for rate review. First, hospitals may apply uniform accounting practices to the presentation of information in the 301 form, thus reducing the variation in reporting practices. Second, rate review staff may make use of the data base that will be assembled from the uniform accounting annual reports to provide a source of consistent financial data across hospitals. Also, the BHE may publish more data relevant to the rate review program when uniform accounting data become available. Last, since the uniform accounting data will include peer group comparisons of selected hospital rates and charges, the BHE rate review staff may rely more heavily on the use of interhospital comparisons in their quantitative analysis.

State Health Plan

The rate review program may be indirectly affected by the implementation of a state health plan. A draft state health plan, developed by the Bureau of Health Planning, has not yet been approved by the State Health Coordinating Council (SHCC).[1] The state health plan, if approved, will supersede the area health plans of the HSAs and establish statewide planning and Certificate of Need criteria. The HSAs will then have to conform to the statewide standards established by the plan rather than to locally developed standards. Uniform planning requirements across the state will reduce the amount of interarea variation in review and planning criteria and will strengthen the role of the state health planning agency, the Bureau of Health Planning (BHP), in the planning functions of the HSAs. It is not yet clear what impact, if any, the state health plan will have on the rate review program. However, statewide rather than area planning may prove beneficial for standardizing the review of rates across HSAs.

Expanding Role of HSAs in Rate Review

While HSAs may lose some planning autonomy when a state health plan is implemented, they are becoming more independent from the BHE in their review of proposed rate increases. Since 1976, all HSAs except the Navajo Nation have been authorized by DHS to conduct rate review and Certificate of Need. Prior to 1976, area-level staff analysis of proposed rate increases was conducted only in CAHSA, the Phoenix area HSA; staff review for the other areas of the state was performed by the BHE. Since 1974, the HSAs have gradually expanded their staff and budgetary resources allotted to rate review. In the early years of the program, the BHE

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[1]There are some obstacles to approval; most notably, the DHS was not redesignated as the SHPDA and is currently undergoing a reorganization.

conducted a detailed staff analysis, while at the area level, the health planning council's staff analysis was limited. Now this trend has reversed. Currently, HSA staff routinely conduct a detailed analysis of proposed rate increases. Since there is not a standardized methodology for evaluating proposed rate increases, HSAs do not have to conform to state review procedures, and staff analysis varies across HSAs.

The increasing autonomy of the HSAs in area-level rate review may produce some minor changes in the rate review program. For example, an institution may take the HSA's rate review recommendation more seriously since the HSA makes Certificate of Need decisions.[1] Providers frequently react negatively to the HSAs' influence on the rate review program. Whereas the BHE has attempted to maintain a cooperative and constructive relationship with providers, providers have at times had adversarial relationships with HSAs in rate review matters.

INTERACTIONS

Overview

The objective of this section is to describe and analyze the roles of the various parts of the Arizona health care system in the development and operation of the rate review program. The first discussion focuses on the HSAs, where special emphasis is placed on public participation in rate review. Next, the role of Certificate of Need and planning in the rate review program is discussed, followed by a description of the roles of the hospital association and the Arizona Legislature. The role of the Arizona Blue Cross is briefly reviewed. Finally, mention should be made that, since Arizona has no operating Medicaid program and since the role of unions is strictly limited in the state's economy, these groups have not been included in the interaction analysis.

Health Systems Agencies

Overview

A striking feature of Arizona's health care regulation system is the decision-making power allocated to the health systems agencies (HSAs). HSAs in Arizona have major regulatory and planning responsibilities which

[1] A Certificate of Need decision can be overturned at the state level only if the HSA recommendation is determined to be capricious and arbitrary or if there are found to be procedural flaws in the HSA review process.

in other states, may be assigned to state-level agencies. The HSAs have primary responsibility for Certificate of Need review, although a state-level agency does have a role in that program; responsibility for rate review is more equally shared by the HSAs and the BHE. Until a state health plan is approved, each HSA is also responsible for developing and implementing an area health plan.

Since the HSA role in the rate review process has already been discussed in the content and process section, this section will focus on a distinctive feature of review at the HSA level: public participation in rate review. Community involvement in rate review through the HSAs is an integral part of the rate review process. HSA recommendations on proposed rate increases are made by volunteer community participants, representing both consumers and providers, and subject to ratification by the HSA's governing body. It should be noted that, although HSA recommendations on proposed rate increases are always channeled through the BHE and the director of the DHS issues the final findings, the HSA recommendations enjoy independent status. If the director's recommendation differs from the HSA's, a health care institution is considered to be in compliance by adopting either of the recommendations.

The initial review of proposed rate increases at the HSA level involves substantial public participation in the review process. HSA members may serve on hearing panels that review proposed rate increases and make preliminary recommendations on proposed rate increases to the HSA board or governing body. The HSA board, which is elected from the HSA membership, makes the agency recommendations on proposed rate increases on the basis of the panels' findings. The board's recommendations are then forwarded to the director of the DHS. The HSA rate review staff analyzes proposed rate increases and is informally involved in the public hearings. However, the staff is not directly involved in making the HSA recommendations.

The public also acts as an external force in the rate review process. Public pressure is considered to be the primary motivation for hospitals to comply with agency recommendations. The success of voluntary compliance depends in large part on an active community interest in the rate review process: the public has to hold hospitals accountable for their financial decisions. The public hearings conducted by the HSA act, to some degree, as a forum in which a community can examine a hospital's finances and planning.

Public Participation in CAHSA

To illustrate the role of the community in the rate review process, public participation in the Central Arizona HSA (CAHSA) is described in detail. It should be noted, however, that public participation varies across HSAs, and the procedures of CAHSA are not necessarily representative of those of the other HSAs.

CAHSA, which has been conditionally designated since 1976 and was formerly a 314B agency, serves the greater Phoenix area, the most densely populated area of the state with approximately half of the state's population. The Phoenix area has had a history of active public and business participation in the rate review process. It was in Phoenix that the Good Samaritan case, which prompted the original rate review legislation, occurred in 1971. The Motorola Company, through its Phoenix-based divisions, has consistently supported the rate review program and was instrumental in its creation. Executives from Motorola have both participated in rate review and worked independently with hospitals to help them improve their financial management, as have representatives from other businesses who are also concerned about the rising costs of health insurance.

In CAHSA, there is a standing rate review committee of approximately sixty people, all of whom are CAHSA members. Persons from this committee are selected to review and conduct public hearings on proposed rate increases, and to make preliminary recommendations to the HSA board. Their participation ranges from six to twenty times a year. A number of people on this committee also serve on a similar Certificate of Need committee, and participation on both committees is entirely voluntary. The composition of the committee includes a fairly broad cross-section of occupations and age groups. Some members, including several accountants, work in insurance or other industries and have a financial background. Several nurses, hospital administrators, and other providers are also on the committee. Still others are homemakers and retired persons who have chosen to commit some of their time to rate review. Motivation for participating in rate review varies from a strong concern about hospitals' patient charges to a desire to use a specialized skill, such as accounting, to benefit the community. Other participants, such as CPAs, may desire to keep abreast of developments in the hospital industry and may feel that their participation might lead to business opportunities.

The HSA board of directors, which is elected by the HSA membership, consists of a predetermined mix of consumers and providers as established in the National Health Planning and Resource Development Act (PL 93-641). The board consists of thirty members, a majority of whom must be consumers. One-third of the members must be providers, who are defined as persons representing health professionals, health care institutions, health care insurors, health professional schools, and the allied health professions. Efforts are made to maintain the above ratio of consumers to providers on the rate review committee and the hearing panels.

The public hearings at CAHSA are conducted in the following manner. One HSA board member is appointed to be chairperson of the rate review committee. When the HSA analyst sets a hearing date for a rate review,

the rate review chairperson is notified. The chairperson then selects a panel from the rate review committee to conduct the hearing; the panel consists of from three to six people, usually four or five. The chairperson also selects one of these people to chair the panel. The chairperson of the panel conducts the hearings according to Roberts' Rules of Order, and panel recommendations are based on a majority vote by its members.

There are no formal guidelines for selecting a panel, but usually the rate review committee chairperson tries to include one accountant on the panel and to select someone who is a veteran panel member to chair the hearing. An attempt is made to select panels that are "mixed" in terms of professions represented, length of time on committee, quantitative skills, and attitudes toward the hospital industry. The institution under review has the right to reject panel members on the grounds of conflict of interest or prejudice, but such requests are not necessarily honored.

Participation on the rate review committee is a demanding commitment requiring considerable motivation, and members are not paid for their work. The typical committee member may spend eight to ten hours a month at rate review hearings. An average hearing lasts two to four hours, in addition to which the panel member spends time studying the rate review package and staff questions. A small group of committee members may put in twenty to thirty hours a month attending and chairing hearings.

Review panels may vary considerably in the rigor and thoroughness with which they examine a hospital's proposal for a rate increase. The mix of people on a given committee will affect the outcome of the hearing, i.e., the preliminary recommendation. The variation in the rigor of panel recommendation is mediated, however, by the subsequent review of the panel recommendations by the HSA Board and of HSA recommendations by the BHE. It is also possible that variation in specific panel recommendations is less important than the orientation of the HSA towards the hospital industry. CAHSA, an older organization, has been accused by some of being too lenient with hospitals, while the newly formed Western Arizona HSA (WAHSA) has a reputation for being tough, or at least stubborn. A contributing factor here, however, is the fact that WAHSA has jurisdiction over five relatively small hospitals, whereas CAHSA reviews thirty-two hospitals, ranging from twenty to 720 beds.

Nevertheless, because of the emphasis in Arizona on local involvement in rate review, a discussion of review by the public hearing body is important. Not all of the HSAs have separate rate review committees distinct from the governing bodies. Public hearings in WAHSA, for example, are conducted by an ad hoc subcommittee of the HSA governing body. This system could result in more consistent behavior, but not necessarily more stringent recommendations.

The inexperience of some panel members is acknowledged as a flaw in the review process. It has been debated whether consumers who may lack financial acumen and political sophistication are an appropriate match for a skilled team of hospital managers. On the whole, both HSA staff and committee members interviewed thought that the average consumer could learn the skills necessary to conduct rate review. Analysis of the 301 form is facilitated by the HSA staff analysis and questions, which are made available to panel members ten days prior to the hearing. To guard against the domination of the panel by hospital management, the rate review committee chairperson attempts to mix new committee members on panels with more experienced rate reviewers.

It is interesting to note that "tough" panel review is not necessarily associated with technical expertise. Accountants, providers, and business persons, while they be professionally well equipped to examine hospital managers, may nonetheless be overly lenient with their professional peers. A hospital administrator serving on the rate review committee might be willing to overlook the flaws in a hospital's justification of a rate increase because he is sympathetic to the hospital's desire for growth. It is often consumers with no professional training relevant to rate review who are the most rigorous in their examination of proposed rate increases. For example, a retired person concerned about the effects of rate increases on persons with fixed incomes might demand a detailed justification from a hospital proposing a large rate hike.

Another component contributing to the inconsistency of panel review (and HSA board recommendations) is that of selective bias. A number of people on the committee have special interests that may selectively influence their recommendations. For example, there is a higher concentration of beds in central Phoenix hospitals relative to hospitals in outlying communities. Many people in adjacent towns such as Mesa have recently joined CAHSA[1] to have a voice in decisions about future bed allocations. Although bed ratios are a Certificate of Need concern, rate review committee members with this special interest may be more lenient toward outlying hospitals than toward those in central Phoenix. Representatives on the board, elected from the HSA membership, might reflect that concern as well.

In general, a rate review committee with a wide spectrum of professional and special interests is seen by the HSA as a valuable contribution to the rate review program. The diverse perspectives of committee members are seen as a kind of insurance against systematic bias. The variability of review, which is a function of the mix of individuals on a particular panel, is seen as preferable (in CAHSA) to a possible built-in bias. A large rate review committee has the additional advantage of representing a wider cross-section of the HSA population. Relationships within

[1]CAHSA now has over 2,000 members.

an HSA sometimes become delicate and strained when the review panel's decisions are not supported by the final HSA decision makers. A further complexity has recently been introduced through the implementation and use of HSA subarea councils. Such councils are now acting as an intermediary between the review panel and the HSA's governing body. Thus, to protect its interests, an applicant is represented at three HSA review levels.

Another factor affecting the quality of HSA review is the continuity of staff and HSA board and rate review committee members. Since Arizona does not have standardized review criteria, continuity of participants in rate review is especially important to providing more uniform review. An awareness of a hospital's past behavior may provide valuable insights into its proposed plans. The problem with the reliance on public participation in rate review, then, is the turnover of committee and board members. Probably the most important criterion for rate review committee members is experience in conducting rate reviews. Unfortunately, the time commitment necessary to serve on panels or the HSA board may become too burdensome for some people after a year or two. In some cases, members serve for a few years and then agree to serve indefinitely on a limited basis; for example, for certain hospitals. Such individuals are invaluable to the process, since they have continuity of review and become knowledgeable about the operating and financial aspects of specific hospitals. However, the turnover of committee and board members is a problem frequently faced by the HSAs.

Interaction between rate review committee members and financial managers of hospitals has declined since the beginning of the program. In the early 1970s, members of the business community believed that hospitals, especially nonprofit institutions, could benefit from the management and planning expertise of the private sector, and some businessmen volunteered to work with hospital managers. This interest in improved hospital planning, as exemplified by Motorola's work with Good Samaritan Hospital in Phoenix prior to the implementation of rate review, carried over into the rate review program. During the early years of the program, committee members would actually tour hospitals and ask questions about operating practices and, on occasion, suggest ways to improve management practices. Now the program seems to be more narrowly focused on rate review and is not directly involved in the improvement of hospital planning. The decline in business and community involvement in the issues of hospital cost control has been partially offset by the increase in professional staff at CAHSA and by the HSAs' assumption of greater responsibility for rate review.

To conclude, the review of proposed rate increases by consumer hearing panels and the HSA board is an integral part of the rate review process. The interaction between HSA members and providers seeking rate increases ensures that hospitals must publicly account for their financial

decisions to at least a small segment of the communities they serve. The public hearing process greatly facilitates the full public disclosure of the hospital's financial records.

The mechanism of panel review has the disadvantage of built-in inconsistency. There is not a standard methodology for the review of 301 forms, nor are there uniform criteria for the evaluation of proposed rate increases. Since the mix of people on a particular review panel can vary substantially in terms of professional and special interests, rate review experience, and technical skill, the rigor and thoroughness of review can vary from panel to panel. There are a number of checks against the variability in panel recommendations, such as a subsequent review by the HSA board. However, the flexibility of panel review undoubtedly results in some inconsistency in panel recommendations.

Other Agencies: Certificate of Need and Planning

The rate review, Certificate of Need, and planning agencies are situated close to each other, both in the HSAs and within the state's organizational structure.[1] Interactions among the three programs, especially between rate review and Certificate of Need, are greater at the HSA level than at the state level. In general, the proximity of rate review to other regulatory and planning agencies facilitates information and data sharing. Hospitals are aware, for example, that a rate review analyst can easily discover if a Certificate of Need exists for a large proposed expenditure. However, there are few formal linkages among the three programs; neither Certificate of Need nor planning staff at the state and local levels formally participate in the review of proposed rate increases. Thus, the advantages of physical and organizational proximity are partly offset by the lack of routine interaction and the constraint of heavy workloads.

Structure

The Department of Health Services (DHS) is conditionally designated as Arizona's SHPDA. SHPDA's functions within the DHS are performed by the Division of Health Resources. Rate review (Bureau of Health Economics), Certificate of Need (Bureau of Survey and Construction), and planning (Bureau of Health Planning [BHP]) are all functions of the Division of Health Resources. Offices for the three bureaus are in the same building.

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[1]For a more detailed description of Arizona's rate review and Certificate of Need programs in 1976, see Rowland's "Coordinating Certificate of Need and Rate Review in Arizona" in J.B. Brown, D. Rowland, and M. Sweetland, Exchange of Information Between Hospital Rate Setting and Certificate of Need Agencies: Selected State Experiences. Cambridge: Harvard University Center for Community Health and Medical Care, Report Series R-45-14, October 1976.

The relocation of rate review and planning within the state bureaucracy since the rate review program began in 1972 has probably facilitated informal interaction between the two bureaus. Rate review, Certificate of Need, and planning were responsibilities of the Arizona Health Planning Authority (AHPA) from 1973 to 1974; several key staff in the BHE and BHP formerly worked together in the old AHPA.

At the local level, rate review, Certificate of Need, and planning staff work in close proximity within each HSA. In HSAs #3 and #5, in the northern and western parts of the state respectively, the time of one staff person is evenly divided between rate review and Certificate of Need review. Community participants in the HSAs also provide an important link between rate review and Certificate of Need. The HSA board makes recommendations on proposed rate increases and Certificate of Need applications. Also, many volunteer participants who serve on panels to conduct public hearings for rate review also conduct hearings for Certificate of Need.

Certificate of Need

The Certificate of Need program applies to expenditures of $100,000 or amounts in excess of three percent of the institution's annual operating expense budget, whichever is less. Scope of coverage includes capital expenditures above the dollar threshold, increases in bed capacity, new medical services, and substantial changes in medical services if they result in expenditures of $50,000 or more within a twelve-month period (Arizona Statutes, Section 36-433 (A)).

Authority for Certificate of Need review rests almost solely with the HSAs, while authority for rate review is divided between the HSAs and the DHS. State Certificate of Need staff have a minimal but legally mandated role in the review process. An HSA recommendation can be overturned at the state level only if there are procedural flaws in the HSA review process or if HSA findings are determined to be arbitrary and capricious. Since Certificate of Need decisions are mandatory and can be appealed, review procedures and public hearings must be conducted in strict accordance with established administrative procedures. As a result, Certificate of Need review has a formal review procedure in contrast to the more informal rate review process.

The state locus for Certificate of Need is in the Bureau of Survey and Construction (BSC). The BSC also has responsibility for Hill-Burton projects, code compliance and construction permits for health care and child day care facilities, and supervision of architecture and construction. DHS resources assigned to Certificate of Need provide for a BSC staff analyst and an attorney, each of whom devote approximately seventy-five percent of his time to the program. Another attorney in the director's office (DHS) usually handles appeal cases.

The BSC routinely sends copies of Certificate of Need applications to the BHE rate review staff, who may use the applications as an additional source of information in conducting rate reviews, and BHE files are accessible to both the BSC and planning staff. Other exchanges between the BHE and BSC are occasional rather than routine. The BHE files are accessible to both the BSC and planning staff. Rate review staff notify the BSC if they spot a large proposed expenditure that may not be authorized by a Certificate of Need. The BSC has uncovered several Certificate of Need violations that were first discovered by rate review staff. The BSC plans to use the Uniform accounting data base, which is currently being developed by BHE staff.

Informal interaction between rate review and Certificate of Need staff is greater at the HSA level. Usually, both staffs share a common HSA data base; files are accessible and may be kept in the same room. In two HSAs, Certificate of Need and rate review analyses are performed by the same person. However, proposed rate increases are not routinely reviewed by CON staff as a part of the rate review process.

In the CAHSA, attempts are being made to integrate rate review and Certificate of Need analysis. Certificate of Need staff routinely ask rate review staff about expenses and staffing levels presented in CON applications, and rate review staff check to see if proposed expenditures have Certificates of Need. Staff in each program are attempting to attend selected hearings of the other program, but heavy case loads severely limit the ability of staff to integrate their review procedures.

As mentioned earlier, further continuity in rate review and Certificate of Need review is provided by community panel and HSA board members, who may review both Certificate of Need and rate review cases. An earlier study on Certificate of Need and rate review in Arizona[1] observed that hospitals tend to present a rather different financial picture to CON reviewers than to rate reviewers. Continuity of review committees may serve as a check to an institution's presenting an optimistic picture on a CON application and one of impending financial doom on an application for a rate increase.

The impact of CON-approved projects and expenditures on a hospital's proposed rate increase is not formally determined during the course of a rate review. Although hospitals are not required to refer to Certificate of Need in the capital acquisition statement included in the 301 form, the CON status is checked by the rate analyst. However, hospitals applying for a Certificate of Need must assess the impact of the expenditure or service on the existing rate structure. Both rate review and CON staff interviewed thought that rate reviewers "recognized" expenses associated with approved

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[1]Rowland, op. cit.

Certificates of Need, but were stringent with proposed expenditures for which no Certificate of Need had been granted. Both rate review and Certificate of Need staff have been frustrated by a provider tactic for which there is no legal remedy: hospitals frequently incur enormous cost overruns on Certificate of Need projects, which are passed through by rate reviewers because they have no legal authority to disallow such expenses. A Certificate of Need analyst observed that if compliance with agency rate recommendations were mandatory, rate reviewers could more easily control cost overruns.

Planning

At the state level, the relationship of the BHE and the Bureau of Health Planning (BHP) resembles the relationship of the BHE and the BSC. Planners do not formally participate in rate review, but there is an informal exchange of information and data between the two bureaus. BHE staff inform the BHP of hospital activities that may interest planners. For example, when the BHE discovered in the course of a rate review that a proprietary hospital was planning to close down in an underserved area, this information was passed along to planners.

The BHP is responsible for the compilation and dissemination of health care data for the Department of Health Services. In the future, planners will use data generated by the Uniform Accounting Program in preparing BHP statistics. BHP staff also participated in the development of the peer grouping methodology for the Uniform Accounting System.

Arizona, it should be noted, does not currently have a state health plan. Each HSA has an area health plan that it uses to conduct Certificate of Need and other planning and regulatory activities. However, a draft state health plan was to have been approved early in 1979.[1] BHE staff reviewed and made recommendations on the draft state health plan.

Planners and rate review staff have an informal relationship at the HSA level. The review committees, however, are not involved in planning. Rate review and planning staff interact more frequently than they do at the state level, primarily through the informal exchange of information and data. Rate review staff may also review or participate in the development of area health plans. However, planners do not formally participate in the review of proposed rate increases, and informal interaction may be limited by time and staffing constraints.

[1]The state health plan had not been approved as of June 1979.

Summary

In general, rate review staff at both the state and HSA level informally interact with Certificate of Need and planning staff, primarily through the exchange of information and data. The organizational proximity of the three programs in the HSAs and in the Division of Health Resources makes the Certificate of Need and planning staffs accessible to the rate review staff. Two other links exist at the HSA level between the Certificate of Need and rate review programs: members of the HSA board and rate review committees may review both Certificate of Need applications and proposed rate increases; more importantly, hospitals may go along with a rate review recommendation in order to facilitate the approval of their Certificate of Need applications.

There are several limitations on potential interactions. With one exception,[1] no formal, mandatory linkages exist between rate review and Certificate of Need or between rate review and planning. For example, rate review staff do not formally participate in Certificate of Need review and vice versa. Also, physical accessibility of other programs may be offset by the lack of time and staff available to exchange information and data. For example, CON analysts are not required to review requests for proposed rate increases. Since Certificate of Need and planning staff do not formally participate in rate review, interaction between the programs is limited by the availability and inclination of individual staff members.

To conclude, while the proximity of rate review, CON, and planning within the DHS and HSAs facilitates interaction, the lack of mandatory linkages precludes formal, consistent participation among the programs.

Hospital Association

At present, the Arizona Hospital Association (ArHA) is a growing organization, which provides services to its members in two major areas. One service area is for operations internal to the industry. The Association is active in cost containment and sponsors a major program to disseminate cost-saving program information to its members. The Association is also active in the regulatory area. A planner is being added to the staff to assist the members in meeting the problems engendered by planning legislation. The major activity of the Association relative to regulation continues to be in the legislature as a spokesperson for the hospital industry. The Association's basic position is that the state's growing population will continue to support a growing demand for hospital

[1]Certificate of Need reviewers must consider the impact of proposed capital expenditures on a hospital's rate structure in the review of a Certificate of Need application.

care and that the major concern is to plan for the orderly growth of the industry. The support of the rate review program by the Association can probably be traced to its view that rate review is not now a threat to the industry's expansion.

The Arizona Hospital Association's position on the rate review program is and has been supportive. This is not to say that the Association, as the representative of the state's hospitals, is an enthusiastic supporter; rather, its attitude has been that the program's present regulatory form is more than tolerable. The relationship of the Association with the Bureau of Health Economics (BHE) has been and continues to be favorable, and contact between the two groups to discuss mutual or individual problems is frequent.

The following discussion is an analysis of the relationships between the hospital association and the rate review agencies.

In contrast to the BHE, the Association's links with the regional HSAs are not at the same high level of cooperation. Although its relations with the hospital association have been positive, one should not infer that the BHE has been captured by the hospital sector; such a conclusion would require more evidence than is now available. The helpful relations between the two groups can, instead, be attributed to the fact that the BHE is carrying out its responsibility under the rate review legislation. Because the law requires both full financial disclosure and a concern, if not a guarantee, for the financial viability of Arizona's hospitals, a high degree of cooperation from the state agency and the hospital association would seem to be required. At the same time, the full disclosure and financial viability concerns of the law do not mean that the hospitals and other institutions have a blank check to meet their needs. The hospitals must allow the knowledgeable and experienced staff members to scrutinize their financial condition. As a result, institutions cannot pass through any unusual proposed expenditure without a thorough explanation, a procedure that the providers would prefer not to endure.

The program has been criticized by the Association from an operational perspective. In particular, the 301 form is not considered to be sufficiently informative and the hospitals are often asked for additional information. According to a hospital association official, a large Phoenix hospital required 3.5 person months to put together the rate review filing package. However, some criticism about the bureaucratic burden of a program such as rate review is probably to be expected.

The relationship between the hospital Association and the HSAs has been more controversial. The basic position of the Association and the hospitals it represents is that the function of the HSAs in the rate review program is to monitor rates and charges and to protect the financial

viability of the hospitals, which is a strict interpretation of the original legislation. The HSAs, in the opinion of the Association, do not always take the strictest possible interpretation of the law. In the early years of the program, a burning issue was the degree to which the rate review program was to be involved in the internal operations of a hospital. Under the leadership of the Samaritan Hospital system, the hospitals have resisted a line-by-line review of their budgets.

As mentioned earlier, the rate review panels from the CAHSA and its predecessor, a 314B agency, often visited hospitals and surveyed their operations. This approach was seemingly beyond a strict interpretation of the law, yet the law does not clearly prohibit an investigation into the factors behind the financial information. Because of the voluntary nature of compliance under the legislation, specific procedures cannot be legally enforced. Thus, persons who are rate reviewers cannot have their behavior subjected to a legal interpretation on conformity to state standards such as under an administrative code.

By the same token, the voluntary characteristic of the program protects the providers from what they may consider to be unnecessary prying by allowing them not to answer questions without incurring any legal penalty. The hospital association has objected to the discussion of a wide range of issues which have been brought up occasionally during rate review sessions of the HSA panels. However, our understanding is that the Association has not been the prime force in narrowing the scope of the program to strictly financial matters. Instead, its role has been supportive of the position of the Samaritan Health Service--that the proper role of the HSAs is to concentrate on fiscal matters only. In fact, the Samaritan Hospital system is currently waging a battle to restrict the scope of the review to only those additional costs that result from conditions external to institutions such as inflation.

While the Association's relationship with the HSAs may not be harmonious when the issue is rate review, the situation at present cannot be termed critical. A more strained relationship seems to exist, however, in the Certificate of Need program, where the HSAs have a more dominant role than in rate review. The major emphasis of the Association in the modification of the Certificate of Need program has been in the legislature, a traditional arena for association activity. If the HSAs are able to increase their linkage between the rate review and the planning and Certificate of Need powers that they have under PL 93-641, a more active and aggressive role can be expected from the Association.

The Legislature

In general, the Arizona Legislature is strongly supportive of the rate review program in its present form, as indicated by most of the few key

legislators who are deeply involved in health care issues. The rate review program is considered to be one of the state's best programs. Most legislators believe that Arizona has been as effective or more effective in controlling hospital costs than other states with more restrictive regulatory programs.

The legislature's concerns about health care are centered on two problem areas. The first is the state's lack of a Medicaid program. Some legislators believe that some poor persons are being denied necessary care by Arizona's refusal to fund a Medicaid program, and the likelihood of instituting a Medicaid program in Arizona in the immediate future is remote. The county-financed program that provides hospital and nursing home care to the poor is favored by the legislature and, as indicated in our discussions, by most other groups in the health care system.

Another problem issue in the state is the role of the HSAs in the regulation and planning of the health care system. The fundamental issue is whether or not the primary function of the HSA is to plan or to regulate. Some key legislators believe that the HSAs are more concerned with regulation than with planning, a belief that has generated moves within the legislature to weaken the power of the HSAs. The Certificate of Need program has been the main vehicle for attempting to weaken the regulatory powers of the local agencies.

In the 1977-78 legislative year, a program to alter the Certificate of Need program was passed by the Arizona House in the waning hours of the session, but the Senate adjourned before acting on the legislation. The bill, actively supported by the Arizona Hospital Association, would have raised threshold levels for hospital investments and redefined medical services so as to lessen the regulatory ties on the providers. Similar legislation will probably be reintroduced during the current session. One key legislator has openly advocated the removal of the nursing home industry from the Certificate of Need program.

The legislature is unlikely to tamper with the rate review program; its attention in the health care field will be focused on the HSAs and their Certificate of Need and planning programs. Some of the hostility of the legislature toward the HSAs seems to be related to the personalities in the system and to the legislature's aversion to the procedures of the HSAs. Another interpretation is that the legislature has accepted hospitals' position that the function of the HSAs is to plan for the orderly growth of the industry and that their present practices are counterproductive. The best information available is that, while the HSAs may have their critics in the legislature, they also have powerful allies in the business community who will probably try to thwart any effort to alter the present planning and regulatory functions of the Arizona HSAs in a fundamental way.

Third-Party Payors--Blue Cross

Although Blue Cross is not as dominant in Arizona as it is in many eastern states, the charge-paying organization has gained about fifteen percent of the market for health insurance. The Blue Cross Association has a strong interest in cost containment and is generally supportive of the Arizona rate review program as supplemental to its general cost control strategy. The Association also supports its own cost containment committee and is actively promoting sound preventive health practices and the use of deductibles to reduce the demand for hospital care.

A major concern of the Association is the drive of hospitals to become full-service facilities. Some dissatisfaction was expressed about the CON program's effectiveness in curtailing investment; physicians, it was pointed out, often bypass the program by putting medical equipment in their own offices. However, the rate review program is considered by the Association to be most effective. The program was cited for its checking of the rates of increases in the charges of the larger Phoenix hospitals. It was also mentioned that the fiscal surpluses of hospitals are not disproportionate. Blue Cross supports the voluntary aspect of the program to the extent that Blue Cross officials in the Phoenix area often participate in the HSA panels.

The key aspect of the interaction between Blue Cross and the rate review program is the Association's position that it will not recognize an increase in rates and charges of a hospital until receiving proof (state findings) that the hospital has followed the proper process. In the event the hospital implements a rate level higher than that endorsed by the state, Blue Cross reserves the right to do an independent audit on the hospital's financial condition prior to accepting the new rate structure. Although not yet tested, it is assumed that, if the audit validates the finding that the rate increase is excessive, Blue Cross will not pay the full amount of the newly implemented charges. Although free under law to continue the charges for self-pay patients, it is extremely doubtful that the hospital would continue the new charges in the face of such opposition and a multilevel charge structure. This support by Blue Cross is an important factor in making voluntary compliance a workable system.

PROGRAM RIGOR, EQUITY AND EFFICIENCY

Program Assessments

In 1977, ninety-five institutions filed rate increase packages with the Arizona rate review program. Of the fifty-three hospitals filing for increases, only one institution (two facilities) chose not to comply with the rate recommendations of either the local HSA or the DHS. During the same year, out of thirty-five nursing care institutions filing for rate increases, four institutions did not comply with the HSA's rate

recommendation, including one that did not comply with either the HSA's or the state recommendation. In 1976, a similar low rate of noncompliance was observed for hospitals, with a higher noncompliance rate for nursing care institutions. In the early years of the program (1972 through 1975), the program was even more successful in securing hospital compliance. Until the end of 1975, not a single hospital had defied a mutual recommendation of the state and local agencies to reduce a proposed rate increase. Thus, with the possible exception of small, proprietary nursing care institutions, the record of compliance with review recommendations has been excellent.

If compliance with rate recommendations were the sole criteria for the evaluation of the program, the program would have to be judged an outstanding success. However, although the compliance rate is often cited as the reason for the program's support among most factions of the state's health care system, a moment of reflection would suggest the danger in a one-dimensional criterion. If compliance were the sole criterion, the danger of trading other important program goals such as cost control in return for more compliance would be troublesome. A high rate of compliance is not, of course, the objective of the program. Rather, a high compliance rate is a necessary condition for program success. A voluntary rate review program riddled with defections would soon disintegrate. Arizona's program has been remarkably stable with only slight signs of disaffection. It would, however, be naive to expect that the program never compromised on a hospital's rate request in order to ensure its compliance. As noted in the discussion of the program's process, negotiations occur at many points in the review cycle, which seemingly provide opportunities for trading off higher rates for compliance.

While the high compliance rate is often cited as the basis for the program's support and its longevity, the favorable comparison of the program with other states in terms of price increases is put forth as evidence for the program's effectiveness. Almost without exception, everyone interviewed was of the opinion that Arizona's program was at least as effective as the programs of other states in controlling costs. At the same time, no one would say that the program had fundamentally altered the health care delivery system in the state. The implication is that the program, if effective, has reduced waste or inefficiencies in the delivery of hospital care.

The empirical basis for the stated effectiveness of the program is a frequently cited consultant report, which analyzed hospital expenditures in the period 1967-76. A quotation from the report is illustrative of the evidence in support of the Arizona program:

> Some voluntary cost control efforts appeared to control costs without squeezing net incomes--although we did not conduct a comprehensive analysis of all voluntary programs, those in Arizona and Minnesota appeared to exhibit a positive impact on revenues and expenditures per case without disrupting net incomes. . . .[1]

The study then presents a statistical comparison of the data noted above for Arizona (and Minnesota) and an average for a selection of regulated states and for the nation.

For the period 1974-76, Arizona had lower average annual rates of change in revenues and expenditures per case than the regulated states' average and the national average. Arizona's hospitals also had a higher average net income as a percentage of revenue than the hospitals in the regulated states, but a lower rate than the national average.

Additional data, presented in a memorandum of the BHE, provides further evidence to support the popular view that the program has been effective.[2] In the memorandum, a table of comparisons is included for the period 1972 through 1977. A key comparison is the average percentage increase in gross patient revenues (GPR) due to price factors in Arizona and the percentage increase in the Consumer Price Index (CPI) Hospital Service Charges. From 1972 to 1977, for every year except 1974, the percentage rate of increase in the CPI Hospital Service Charges outstrips that of Arizona's percentage increase in GPR. For the CPI - Hospital Service Charge, the average of the percent increases for the period 1973-1977 was 10.04, as compared to the average percent increase in GPR for Arizona of 8.02.

While the above evidence, derived from studies with a simple research design, can hardly be described as conclusive, its availability and the lack of counterevidence are an important part of the basis for the program's political and professional support. The task of the study of rate setting in the several states across the nation will be to assess programs such as Arizona's; the study will be designed to incorporate and to measure explicitly the effects of other potential causal factors on the hospital sector. However, in this initial and qualitative assessment of the program,

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[1] "Background Data on Changes in Hospital Expenditures and Revenue," ICF Incorporated, February 1978, p. 6.

[2] "Hospital Rate Increases, State of Arizona v. U.S. Average," Bureau of Health Economics Interoffice Memorandum, Arizona Department of Health Services, January 4, 1978.

any judgments based on sketchy quantitative information would be premature and unwise. Instead, the emphasis will be placed in this summation on a description of the program's characteristics.

These characteristics include the program's rigor, efficiency and equity. An accurate characterization of the program will, in turn, provide the basis for testing a general hypothesis that a program with certain characteristics is more or less effective than programs with other characteristics.

Rigor

The Arizona rate review system can be described, to use a term of some students of hospital regulation, as a laissez-faire program, which implies nonrigor. The lack of a rate-setting commission with its attendant panoply of state powers and regulations, coupled with the voluntary compliance aspect of the program, probably constitute the two major factors that have set the tone of the program's policies and procedures. The assignment of important program responsibilities to what are essentially planning agencies is also indicative of the program's character. The politically conservative environment of the state precludes an open embrace of a tough regulatory program.

With the limited power of the program diffused through a two-tier administrative system, and with the rate reviewing function itself scattered among health professionals, public administrators, consumers, accountants, providers, and business executives, the program, it is clear, was not designed to monitor hospital behavior very closely. In practice, the program's policies and procedures have evolved to the point where a concern about the financial viability of a hospital is equal to the concern over the reasonableness of its rate requests.

The scope of the rate review process has, over time, been reduced to an almost exclusive concentration on the increase in prices due to volume and inflation, with little or no systematic attention paid to the hospital's internal operations, such as its buying procedures. In fact, inflation due to external forces has just about become a cost pass-through. If the general inflation rate is projected to be nine percent and a hospital requests a ten percent increase, the scope of the review is likely to be concentrated on the one percent difference. The scope of the review is also limited in the depth of its concern about the results of the hospital's internal operations. In particular, except at the most aggregate level, information on case mix and related quality of care issues is not presented, although a discussion of issues such as quality of care or management practices may surface at an HSA panel meeting. However, such events are likely to be infrequent because of the difficulty of detecting such problems

given the limited information presented to the panel. One observer has noted that the more perceptive panel members may detect anomalies in the statistics presented for review, but these anomalies are nearly always explained by the hospitals. Also, it is worth noting that the right of the institution to challenge the assignment of a possibly hostile person to a rate review panel could be an important factor in lessening the rigor of the panel's review. Finally, at the BHE, issues such as quality of care are not a concern unless they can be directly linked to financial needs. For example, higher-than-expected nursing salaries may be noted in the financial data but be waived through because of the need to attract staff into a rural area. The program's incentive structure is based primarily on public disclosure and is devoid of penalties, screens, or other methods that might link hospital costs with the hospital services actually provided.

Although the other planning and regulatory programs, including Certificate of Need, are also within essentially the same organizational structure, these programs have not yet been consolidated into a cohesive regulatory force. At the state level, linkages between the rate review program (BHE) and Certificate of Need (BSC) are strictly informal and basically limited to exchanging information. The BHE, because of its small staff, is limited in the range of all its activities. The state planning agency, the Bureau of Health Planning, has played little or no role in either rate review or Certificate of Need. Until the BHP has fulfilled its responsibilities under PL 93-641, state planning will have no potential to affect rate review in the state. At the regional level, the rate review, Certificate of Need, and planning functions are within a single agency, the local HSA, and there has been some movement toward integration. In the CON program, for example, the rate implications of an investment must be analyzed as part of the submission. However, HSA efforts to integrate the two programs further have been slow to develop. The opposition of the hospital association, which has opposed the current CON program, is a factor in thwarting integration of the two programs, and the legislature is unlikely to do anything to strengthen the CON program or the rate review program.

In sum, the rate review program lacks the organizational structure, the legal sanctions, the financial incentives, and the political support and authority to be classified now or in the future as a rigorous program.

Equity

The voluntary compliance aspect of rate review in Arizona frees the program from an involvement in court cases related to its rate recommendations and thus precludes the costly and embittering cases that characterize some programs in other states. At the same time, the lack of a legally

mandated set of regulations and procedures does allow for a certain amount of arbitrary behavior by the rate reviewers. This charge is frequently leveled at the panel members on the HSA committees. The BHE, on the other hand, is not subject to such criticism. The arbitrariness of the HSAs can be related to the variability in the mix of persons who participate in rate review. Since a mix of persons with diverse interests is a desired objective for promoting public participation, the sacrifice of some amount of fairness is probably desirable because it promotes a wider participatory base.

Another source of inequitable treatment often alleged to exist is the extra scrutiny to which larger hospitals are sometimes subjected by the review panels and the BHE. However, to treat nonequals (i.e., the larger as opposed to the smaller hospitals) unequally is not necessarily a violation of a generally accepted principle of equity. Larger hospitals do have easier access to resources that may be needed to cope with close scrutiny by rate reviewers.

Aside from the problem of some arbitrariness at the HSA review level, the program cannot be described as inequitable, primarily because the review process is centered on the individual institution with a minimum reliance on interhospital comparisons. In a voluntary compliance program, the unfair treatment of many hospitals would quickly result in general defiance of rate recommendations. Even in the case of an isolated hospital receiving unfair treatment, the remedy of noncompliance is also available. Since noncompliance is not frequent, it might be inferred that the program is not perceived to be inequitable.

Efficiency

Any final judgments about the efficiency of the Arizona rate review program are, of necessity, premature because of a lack of conclusive information on its effectiveness. If, however, the program can be assumed to be effective, then some preliminary assessment of the program's relative cost can be made. This assessment is based on the cost implications of two important characteristics of the program: its broad base of participation, and its voluntary compliance aspect. These characteristics work in opposite directions in terms of cost, with the result that, without further data, no quantitative statements can now be made about the program's efficacy in relation to its benefits.

As noted many times in this report, the Arizona program involves the activity of many persons. In addition to the staff and administrators of the state agencies and the regional HSAs, who are responsible for program direction, many persons from the community at large participate in rate review, mostly as members of HSA panels and governing boards. Their commitment to the program in terms of time is not trivial. As a result,

the Arizona rate review program may be exceptionally costly because of its diffuse structure, which spreads program responsibility among many persons.

On the other hand, because of voluntary compliance, a cost saving undoubtedly ensues. Mandatory programs with their strict adherence to legally required procedures almost always generate court and administrative hearings, which inevitably require costly resources such as lawyers, other court officials, and arbitrators. The Arizona program is essentially immune to costly legal and administrative sessions, which probably reduces program costs relative to mandatory compliance programs. Also, it might be speculated that provider costs are relatively less in a voluntary compliance state such as Arizona.

A very tentative conclusion is that, if effectiveness can be assumed, the Arizona program is relatively more efficient than other programs because of its freedom from legal and administrative delays and their attendant costs.

APPENDIX A

BHE Statistical Summary Sheet

BHE Statistical Summary Sheet

Analysis of Proposed Revenue Increase for

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1. Rate Comparison - Selected Services

Service	Applicant			Sample Statistics (a)			
	Exist. Charge	Prop. Charge	% Increase	Avg. Chg.	% Difference Prop. to Avg. Charges	Range of High	Low
Room	$_____	$_____	_____	$_____	_____	$_____	$_____
Private	_____	_____	_____	_____	_____	_____	_____
Semi-Private	_____	_____	_____	_____	_____	_____	_____
Ward	_____	_____	_____	_____	_____	_____	_____
Nursery	_____	_____	_____	_____	_____	_____	_____
ICU	_____	_____	_____	_____	_____	_____	_____
Surgery:	_____	_____	_____	_____	_____	_____	_____
Major (1st hr)	_____	_____	_____	_____	_____	_____	_____
Minor (1st hr)	_____	_____	_____	_____	_____	_____	_____
Labor & Delivery	_____	_____	_____	_____	_____	_____	_____
Emergency Room	_____	_____	_____	_____	_____	_____	_____
EEG	_____	_____	_____	_____	_____	_____	_____
EKG	_____	_____	_____	_____	_____	_____	_____
Lab	_____	_____	_____	_____	_____	_____	_____
CBC	_____	_____	_____	_____	_____	_____	_____
RU	_____	_____	_____	_____	_____	_____	_____
Radiology	_____	_____	_____	_____	_____	_____	_____
Chest 1 View	_____	_____	_____	_____	_____	_____	_____
Upper GI Series	_____	_____	_____	_____	_____	_____	_____
IVP	_____	_____	_____	_____	_____	_____	_____
IPPB (Rx)	_____	_____	_____	_____	_____	_____	_____
Brain Scan	_____	_____	_____	_____	_____	_____	_____
Lung Scan	_____	_____	_____	_____	_____	_____	_____
Physical Therapy (1 modality)	_____	_____	_____	_____	_____	_____	_____

2. Operating Statistics

	Prior Year	Base Year Amount	Base Year % Change	Projected Year Amount	Projected Year % Change
Inpatient Days					
Admissions					
Outpatient Clinic Visits					
Emergency Room Visits					
Average Length of Stay (days)					
Licensed Beds					
Occupancy Rate (%)					
Full-Time Equivalent (FTE) Employees					
FTE Per Occupied Bed					
Average Age of Accounts Receivable (days)					
Current Ratio					
_____					
_____					
_____					
_____					

3. Financial Statistics

(a) Annual Results

($ in 000)

	Patient Revenue	Reduction of Revenue	Other Revenue	Expense	Net Income/ (Loss)
Prior Year	$_____	$_____	$_____	$_____	$_____
Base Year	_____	_____	_____	_____	_____
Projected Year					
Existing Rates	_____	_____	_____	_____	_____
Proposed Rates Eff. _____	_____	_____	_____	_____	_____
Proposed Rates Annualized	_____	_____	_____	_____	_____

(b) Statistics per Inpatient Day

(1) Year Comparison

	Prior Year	Base Year	Projected Year: Existing Revenue	Projected Year: Prop. Rev. Annualized
Gross Patient Reveue	$	$	$	$
Net Patient Revenue				
Expense				
Net Income/(Loss)				

(2) Comparison to Sample Average

	Applicant	Sample[(a)]: Average	Sample[(a)]: % Difference Prop. to Avg.	Sample[(a)]: Range High	Sample[(a)]: Range Low
Gross Patient Revenue	$	$		$	$
Expense					

(c) Expense Detail

($ in 000)

	Base Year	Projected Year	Changes: Total Amount	Changes: Total %	Changes: Due to Price Amount	Changes: Due to Price %	Changes: Due to Volume Amount	Changes: Due to Volume %
Salaries & Wages	$	$	$		$		$	
Employee Benefits								
Other Expense								
Depreciation								
Interest								
TOTAL EXPENSE	$	$	$		$		$	

(d) Changes in Financial Position

($ in 000)

	Prior Year	Base Year	Projected Year	
			Existing Revenue	Proposed Revenue
SOURCE OF FUNDS:				
	$	$	$	$
	$	$	$	$
APPLICATION OF FUNDS:				
	$	$	$	$
	$	$	$	$

(a)Hospitals used in sample statistics:

Hospital	Location	No. Beds	Effective Date of Price Schedule

Year Key
F/Y/E
Prior Yr:
Base Yr:
Projected Yr:

APPENDIX B

Sample BHF Rate Review Activity Reports

Prior to and Subsequent to 1976

Rate Increases Implemented in 1975

Licensed Non-Federal Health Care Institutions

State of Arizona

	Hospitals	Nursing & Personal Care Institutions
Total no. of institutions	70	71
Total no. of licensed beds	10,026	6,084
No. of institutions:		
- with one increase	40	26
- with two increases	4	1
Total raising rates	44	27
% of institutions raising rates	63	38
% of beds raising rates	74	40
		($ in 000)
For all institutions in State:		
GPR* prior to rate increases	$407,525	$38,570
GPR following rate increases	444,087	40,026
Total increase in GPR:		
Amount	36,562	1,456
Percent	9.0	3.8

*Gross Patient Revenue at Annualized Rates

Bureau of Health Economics
Department of Health Service
January 16, 1976

Rate Increases Implemented in 1975

Arizona Licensed Non-Federal Hospitals

($ in 000)

Hospital	Type[a]	Beds	Date(s) of State Findings	Projected Revenues Annualized			
				Base Rates[b]	New Rates[c]	Increase Amount	Increase %
APACHE COUNTY							
Sage Memorial	NP	45	--	$ 1,876	$ 1,876	$ -0-	-0-
White Mountain (d)	NP	25	--	718	718	-0-	-0-
Total County		70		2,594	2,594	-0-	-0-
COCHISE COUNTY							
Benson	NP	22	12-31-74	481	622	141	29.3
Cochise County	NP	132	11-4-75	2,352	2,675	323	13.7
Copper Queen	M	48	--	1,509	1,509	-0-	-0-
Northern Cochise	NP	24	1-29-75	794	914	120	15.1
Sierra Vista	NP	55	6-27-75	1,391	1,520	129	9.3
Total County		281		6,527	7,240	713	10.9
COCONINO COUNTY							
Flagstaff Community	NP	110	3-18-75	3,946	4,126	180	4.6
NAU Health Center	G	28	--	40	40	-0-	-0-
Page	NP	25	--	568	568	-0-	-0-
Williams	NP	27	--	166	166	-0-	-0-
Total County		190		4,720	4,900	180	3.8
GILA COUNTY							
Gila General	NP	149	1-6-75	2,443	3,201	758	31.0
Miami Inspiration	M	54	--	3,300	3,300	-0-	-0-
Payson	NP	26	--	1,091	1,091	-0-	-0-
Total County		229		6,834	7,592	758	11.1
GRAHAM COUNTY							
Mt. Graham	NP	25	12-31-74	1,109	1,220	111	10.0
GREENLEE COUNTY							
Morenci	M	74	--	1,110	1,110	-0-	-0-

(a) For Type description and other footnotes, refer to page 4 of 4.

($ in 000)

Hospital	Type	Beds	Date(s) of State Findings	Projected Revenues Annualized		Increase	
				Base Rates	New Rates	Amount	%
MARICOPA COUNTY							
Az. Children's Hosp.,(e)	G	162	2-27-75	$ 1,838	$ 2,977	$ 1,139	62.0
Az. State Hospital (e)	G	1,003	3-3-75	1,528	1,756	228	14.9
Az. State University	G	26	8-13-75	76	91	15	19.7
Boswell Memorial	NP	206	12-26-74	7,524	8,264	740	9.8
Camelback	NP	89	6-27-75	2,678	3,113	435	16.2
Community Hospital in Chandler	NP	42	1-29-75	1,101	1,162	61	5.5
Community Hosp. Assoc. - Wickenburg	NP	34	10-27-75	660	769	109	16.5
Desert Samaritan (d)	NP	273	--	11,716	11,716	-0-	-0-
Doctors	P	314	8-27-75	13,030	15,395	2,365	18.2
Glendale Samaritan (d)	NP	62	--	2,927	2,927	-0-	-0-
Good Samaritan (d)	NP	695	--	52,119	52,119	-0-	-0-
John C. Lincoln	NP	202	11-28-75	10,237	11,593	1,356	13.2
Maricopa County	G	495	--	29,246	29,246	-0-	-0-
Maryvale Samaritan (d)	NP	143	--	8,301	8,301	-0-	-0-
Memorial	NP	160	2-21-75	5,504	6,054	550	10.0
Mesa General	P	105	12-31-74	3,878	4,145	267	6.9
Mesa Lutheran	NP	250	12-30-74	12,186	13,329	1,143	9.4
NHE Comm./Phx.	P	50	12-31-74	2,209	2,469	260	11.8
Phoenix Baptist	NP	170	7-31-75	9,021	9,877	856	9.5
Phoenix General	NP	301	7-31-75	10,948	12,168	1,220	11.1
St. Joseph's/Phx.	NP	560	6-30-75	33,724	37,194	3,470	10.3
St. Luke's Hospital Medical Center	NP	400	1-31-75,9-26-75	15,936	18,865	2,929	18.4
St. Luke's West	NP	20	1-31-75,9-26-75	521	595	74	14.2
Scottsdale Community	P	34	--	1,536	1,536	-0-	-0-
Scottsdale Memorial	NP	262	8-8-75	13,599	14,754	1,155	8.5
Tempe Community	NP	110	12-31-74	3,569	3,742	173	4.9
Valley View Community	NP	56	12-12-74	1,720	1,790	70	4.1
Total County		6,224		$257,332	$275,947	$18,615	7.2

($ in 000)

Hospital	Type	Beds	Date(s) of State Findings	Projected Revenues Annualized		Increase	
				Base Rates	New Rates	Amount	%
MOHAVE COUNTY							
Lake Havasu City Comm.	NP	34	--	$ 1,257	$ 1,257	$ -0-	-0-
Lake Havasu City Medical Center	NP	54	--	979	979	-0-	-0-
Mohave General	G	83	--	3,207	3,207	-0-	-0-
Total County		171		5,443	5,443	-0-	-0-
NAVAJO COUNTY							
Holbrook	G	23	--	759	759	-0-	-0-
Navapache (d)	NP	35	--	1,216	1,216	-0-	-0-
Winslow Memorial	NP	42	8-29-75	817	910	93	11.4
Total County		100		2,792	2,885	93	3.3
PIMA COUNTY							
Ameri-Care	P	38	--	313	313	-0-	-0-
New Cornelia	M	33	--	949	949	-0-	-0-
Palo Verde	NP	34	1-31-75	1,394	1,645	251	18.0
Pima County	G	122	--	6,400	6,400	-0-	-0-
St. Joseph's/Tucson	NP	323	8-8-75	15,642	17,503	1,861	11.9
St. Mary's	NP	305	8-28-75	16,503	17,794	1,291	7.8
Tucson General	NP	247	12-26-74,12-27-75	10,161	12,785	2,624	25.8
Tucson Medical Center	NP	557	7-30-75	33,951	37,649	3,698	10.9
U of A	G	28	8-11-75	166	199	33	19.9
University Hosp. (e)	G	300	12-27-74,9-29-75	12,568	16,381	3,813	30.3
Total County		1,987		98,047	111,618	13,571	13.8
PINAL COUNTY							
Hoemako	NP	64	6-30-75	1,654	1,850	196	11.9
Kennecott	M	20	7-8-75	166	188	22	13.3
Magma Copper - San Manuel	M	37	6-16-75	145	226	81	55.9
Magma Copper - Superior	M	22	6-16-75	18	26	8	44.4
Pinal General	G	64	4-25-75	2,031	2,474	443	21.8
Total County		207		4,014	4,764	750	18.7

Hospital	Type	Beds	Date(s) of State Findings	Projected Revenues Annualized ($ in 000) Base Rates	New Rates	Increase Amount	Increase %
SANTA CRUZ COUNTY							
St. Joseph's	NP	81	--	$ 1,700	$ 1,700	$ -0-	-0-
YAVAPAI COUNTY							
Bagdad Hospital	M	11	--	110	110	-0-	-0-
Marcus J. Lawrence	NP	72	5-30-75	2,784	3,030	246	8.8
Yavapai Community	NP	139	12-11-74	3,918	4,272	354	9.0
Total County		222		6,812	7,412	600	8.8
YUMA COUNTY							
Parker Community	NP	36	--	872	872	-0-	-0-
Yuma Regional Medical Center	NP	129	9-24-75	7,619	8,790	1,171	15.4
Total County		165		8,491	9,662	1,171	13.8
TOTAL STATE		10,026		$407,525	$444,087	$36,562	9.0

Totals by Type:

Type	Base Rates		New Rates		Increase Amount		% Increase
G		$ 57,859		$ 63,530		$ 5,671	9.8
M		7,307		7,418		111	1.5
NP	$321,393		$349,281		$27,888		8.7
P	20,966		23,858		2,892		13.8
P,NP		342,359		373,139		30,780	9.0
Grand Total		$407,525		$444,087		$36,562	9.0

Notes:

(a) Type Code: G - Government
M - Mining
NP - Nonprofit
P - Proprietary

(b) Base Rates represent annualized revenue prior to first increase, adjusted by volume changes during interim period to last increase, if applicable.

(c) New Rates represent annualized revenue after implementation of last increase. If no increase implemented, revenue at New Rates is equal to that at Base Rates.

(d) Samaritan Health Service system.

(e) Revenue excludes State appropriation.

Bureau of Health Economics
Department of Health Services
January 16, 1976

Sample Rate Review Activity Report

Bureau of Health Economics

Arizona Department of Health Services

Rate Review Activity, January 1 - December 31, 1977

Health Care Institutions - State of Arizona

($ in 000)

	Hospitals	Nursing Care Institutions	Personal Care Institutions	Other Institutions[b]
Number of Institutions	71	68	22	--
Number of Licensed Beds	9,908	5,297	1,441	--
Number of Institutions raising rates in 1977				
One increase	47	35	4	3
Two increases	2	0	0	--
Total	49	35	4	3
Percent of institutions raising rates	69.0	51.5	18.2	--
Percent of beds raising rates	78.7	53.5	19.6	--

AGPR[a] increases implemented in 1977

	Hospitals		Nursing Care Institutions		Personal Care Institutions		Other Institutions
	Amount	Percent	Amount	Percent	Amount	Percent	Amount
Government	$ 3,759	4.2	$ 322	8.7	$ -0-	-0-	$ 24
Mining	663	9.0	-	-	-	-	-
Non-profit	34,012	8.2	962	7.8	98	4.5	275
Proprietary	2,214	8.7	2,231	7.6	43	0.9	183
Total State	$40,648	7.6	$3,515	7.7	$ 141	1.8	482

AGPR at new rates

Government	$92,257	$ 4,033	$ 786
Mining	8,035	--	--
Non-profit	450,118	13,342	2,292
Proprietary	27,693	31,627	4,891
Total State	$578,103	$49,002	$7,969

	Hospitals	Nursing Care Institutions	Personal Care Institutions	Other Institutions	Total Institutions
Filings processed					
Rate increases	53	35	4	3	95
New services	23	-0-	-0-	-0-	23
Total State	76	35	4	3	118

	Hospitals	Nursing Care Institutions	Personal Care Institutions	Other Institutions	Total Institutions
Compliance with review recommendation					
Institutions voluntarily reducing proposed rates:	10	10	1	1	22
Savings in AGPR from proposed rates:	$ 3,620	$ 293	$ 22	$ 49	$ 3,984

Non-compliance with review recommendation

	Name	Location	Local Agency	State Agency
Hospitals:	Tucson General Hospital	Tucson	*	*
	West Center - Tucson Gen.	Tucson	*	*
Nursing Care Institutions:	Tanner Chapel Manor	Phoenix	*	*
	Hayden Manor	Phoenix	*	
	William-Wesley	Tucson	*	
	Leewood	Tucson	*	

Notes:

(a) AGPR: Annualized gross patient revenue.

(b) Other Institutions include Outpatient Surgical Centers, Outpatient Treatment Centers, Behavorial Health Centers, Supervisory Care Homes, and Health Screening Agencies. Rate Review coverage is partial only, due to lack of resources.

BHE/RS
April 14, 1978

Attachments:

Appendix A: Rate Increases Implemented in 1977 - Hospitals
B: Rate Increases Implemented in 1977 - Nursing Care Institutions
C: Rate Increases Implemented in 1977 - Personal Care Institutions

Rate Increases Implemented in 1977

Arizona Licensed Non-Federal Hospitasls

($ in 000)

Hospital	Type[a]	Beds	Effective Date (s) of Implementation	Projected Revenues Annualized			
				Base Rates[b]	New Rates[c]	Increase Amount	Increase %
APACHE COUNTY							
Sage Memorial	NP	45	--	$ 1,948	$ 1,948	$ -0-	-0-
White Mountain(d)	NP	25	1-01-77	1,002	1,081	79	8.0
Total County		70		2,950	3,029	79	2.7
Cochise County							
Benson	NP	22	12-01-77	701	764	63	8.9
Cochise County	NP	79*	--	3,162	3,162	-0-	-0-
Copper Queen	NP	31*	--	1,378	1,378	-0-	-0-
Northern Cochise	NP	24	--	804	804	-0-	-0-
Sierra Vista	NP	55	7-01-77	1,834	2,050	216	11.8
Total County		211		7,879	8,158	279	3.5
COCONINO COUNTY							
Flagstaff Community	NP	110	4-01-77	5,794	6,335	541	9.3
NAU Health Center	G	28	--	29	29	-0-	-0-
Page	NP	25	--	539	539	-0-	-0-
Williams	NP	27	--	473	473	-0-	-0-
Total County		190		6,835	7,376	541	7.9
GILA COUNTY							
Gila General	G	80*	3-01-77	2,027	2,435	408	20.1
Miami Inspiration	M	54	--	4,195	4,195	-0-	-0-
Payson	NP	26	7-01-77	1,877	2,103	226	12.1
Total County		160		8,099	8,733	634	7.8
GRAHAM COUNTY							
Mt. Graham	NP	25	1-01-77	1,544	1,645	101	6.6
GREENLEE COUNTY							
Morenci	M	74	1-01-77	960	1,184	224	23.3

Hospital	Type[a]	Beds	Effective Date(s) of Implementation	Projected Revenues Annualized			
				Base Rates[b]	New Rates[c]	Increase Amount	Increase %
MARICOPA COUNTY							
Az. Children's Hosp.[e]	G	162	--	$ 2,643	2,643	-0-	-0-
Az. State Hospital[e]	G	800	4-01-77	1,810	2,144	334	18.5
Az. State University[e]	G	26	--	91	91	-0-	-0-
Boswell Memorial	NP	206	9-01-77	12,342	13,606	1,264	10.2
Camelback	NP	89	7-01-77	3,134	3,625	491	12.8
Community Hospital in Chandler	NP	42	9-01-77	1,587	1,587	-0-	-0-
Community Hosp. Assoc. - Wickenburg	NP	34	3-01-77	709	844	135	19.1
Desert Samaritan(d)	NP	273	1-01-77	18,400	20,129	1,729	9.4
Doctor's Hosp.	P	314	1-01-77	15,481	16,698	1,217	7.9
Glendale Samaritan(d)	NP	62	1-01-77	3,409	3,730	321	9.4
Good Samaritan(d)	NP	695	1-01-77	60,732	66,441	5,709	9.4
John C. Lincoln	NP	202	1-01-77	13,017	13,922	905	7.0
Maricopa County	G	495	--	36,479	36,479	-0-	-0-
Maryvale Samaritan(d)	NP	143	1-01-77	9,259	10,130	871	9.4
Memorial Hosp.	NP	160	7-01-77	8,422	9,125	703	8.3
Mesa General	P	105	2-01-77	4,710	5,158	448	9.5
Mesa Luthern	NP	266	5-01-77	17,009	18,697	1,688	9.9
NAI Comm./Phoenix	P	50	3-01-77	2,549	2,887	338	13.2
Phoenix Baptist	NP	221	10-01-77	12,091	13,174	1,083	9.0
Phoenix General	NP	301	--	14,775	14,775	-0-	-0-
St. Joseph's/Phx.	NP	560	7-01-77	45,703	50,045	4,342	9.5
St. Luke's Hosp. Medical Center	NP	400	2-01-77	20,892	22,569	1,677	8.0
St. Luke's - West	NP	20	2-01-77	333	333	-0-	-0-
Scottsdale Community	P	34	10-01-77	2,070	2,241	171	8.3
Scottsdale Memorial	NP	340	--	20,445	20,445	-0-	-0-
Tempe Community	NP	110	1-01-77	2,974	3,547	573	19.6
Valley View Comm.	NP	56	--	2,064	2,064	-0-	-0-
Total County		6,166		$ 330,450	$ 354,978	$ 24,528	7.4

Hospital	Type[a]	Beds	Effective Date(s) of Implementation	Projected Revenues Annualized			
				Base Rates[b]	New Rates[c]	Increase Amount	Increase %
MOHAVE COUNTY							
Lake Havasu City Comm.	NP	34	10-01-77	1,427	1,516	89	6.3
Lake Havasu City Medical Center	NP	54	5-01-77	1,881	2,035	154	8.2
Mohave General	G	83	10-01-77	4,255	4,800	545	12.8
Total County		171		7,563	8,351	788	10.4
NAVAJO COUNTY							
Holbrook	G	23	--	1,263	1,263	-0-	-0-
Navapache	NP	35	--	1,400	1,400	-0-	-0-
Winslow Memorial	NP	42	2-01-77	990	1,057	67	6.8
Total County		100		3,653	3,720	67	1.8
PIMA COUNTY							
Kino Community	G	213	--	15,489	15,489	-0-	-0-
New Cornelia	M	33	12-01-77	1,480	1,919	439	29.6
Palo Verde	NP	34	1-01-77,7-01-77	1,965	2,134	169	8.6
St. Joseph's(Tucson)	NP	325	7-01-77	21,675	23,396	1,721	7.9
St. Mary's	NP	305	7-01-77	20,181	21,892	1,711	8.5
Tucson General Hosp	NP	217	12-01-77	12,575	13,431	856	6.8
Tucson General-West	NP	31	12-01-77	956	1,101	145	15.2
Tucson Medical Center	NP	557	7-01-77	43,865	46,679	2,814	6.4
U of A	G	22	--	227	227	-0-	-0-
University Hosp.(e)	G	300	7-01-77	21,487	23,959	2,472	11.5
Wilmot	P	38	10-01-77	669	709	40	6.0
Total County		2,075		140,569	150,936	10,367	7.4
PINAL COUNTY							
Hoemako	NP	64	1-01-77,7-01-77	1,961	2,605	644	32.8
Kennecott	M	20	--	163	163	-0-	-0-
Magma Copper/San Man.	M	37	--	186	186	-0-	-0-
Magma Copper/Superior	M	20	--	91	91	-0-	-0-
Pinal General	G	95*	--	2,698	2,698	-0-	-0-
Total County		236		5,099	5,743	644	12.6

Hospital	Type[a]	Beds	Effective Date(s) of Implementation	Projected Revenues Annualized			
				Base Rates[b]	New Rates[c]	Increase Amount	Increase %
SANTA CRUZ COUNTY							
St. Joseph's(Nogales)	NP	57	3-01-77	$ 1,162	$ 1,348	$ 186	16.0
YAVAPAI COUNTY							
Bagdad	M	11	--	297	297	-0-	-0-
Marcus J. Lawrence	NP	62*	7-01-77	3,871	4,357	486	12.6
Yavapai Community	NP	100*	1-01-77	4,826	5,398	572	11.9
Total County		173		8,994	10,052	1,058	11.8
YUMA COUNTY							
Parker Community	NP	36	--	1,321	1,321	-0-	-0-
Yuma Regional Medical Center	NP	164	10-01-77	10,377	11,529	1,152	11.1
Total County		200		11,698	12,850	1,152	9.8
TOTAL STATE		9,908		$537,455	$578,103	$40,648	7.6

Totals by Type:	Type	Base Rates		New Rates		Increase Amount		% Increase
	G		$ 88,498		$ 92,257		$ 3,759	4.2
	M		7,372		8,035		663	9.0
	NP	$ 416,106		$ 450,118		$ 34,012		8.2
	P	25,479		27,693		2,214		8.7
	P,NP		441,585		477,811		36,226	8.2
	Grand Total		$ 537,445		$ 578,103		$ 40,648	7.6

Notes:

(a) Type Code: G - Government
M - Mining
NP - Non-profit
P - Proprietary

(b) Base Rates represent annualized revenue prior to first increase, adjusted by volume changes during interim period to last increase, if applicable.

(c) New Rates represent annualized revenue after implementation of last increase. If no increase implemented, revenue at New Rates is equal to that at Base Rate.

(d) Samaritan Health Service System.

(e) Revenue Excludes State appropriation.

* Excludes beds used for long term care.

APPENDIX C

BHE Comparative Study of Rates and Charges

COMPARATIVE STUDY OF RATES AND CHARGES

ARIZONA HEALTH CARE INSTITUTIONS

Bureau of Health Economics

Arizona Department of Health Services

August 15, 1978

This comparative study of rates and charges of health care institutions in the State of Arizona is published pursuant to A.R.S. § 36-436D, quoted as follows:

> "At least annually, the director (Department of Health Services) shall publish an in-depth comparative study of rates and charges of all institutions. The director shall consult with representatives of each class or subclass of health care institutions before such comparative studies are published."

Categories of institutions included in the study are hospitals, nursing homes, personal care homes, home health agencies and ambulatory surgical facilities.

The reported rates and charges were those in effect on July 1, 1978, and were obtained from each institution's schedule of rates and charges on file with the Bureau of Health Economics, Arizona Department of Health Services. The rates and charges used have been verified by each institution and the respective reports approved by the Arizona Hospital Association, Arizona Association of Health Care Facilities (proprietary nursing homes) and the Arizona Association of Homes for the Aging (non-profit nursing homes).

Service categories used were selected on the basis of frequency of use and comparability. Even though listed rates and charges were developed on a comparable basis to the extent feasible, it is recognized that due to differences between institutions in services provided within a given rate structure, many rates and charges may not be fully comparable. For example, some hospitals include supporting and professional charges in a base charge whereas others have a separate charge for each service component. Some hospitals base charges on the acuity level of care required, necessitating the use of average rates for the study. Definition of the exact items included in each rate and charge is beyond the scope of this study and, if needed, can be obtained from the Bureau of Health Economics or the respective institution.

Statistics, including the unweighted mean and range, are provided by size and geographic category and for total state for hospitals and nursing homes. Statistics for personal care homes, home health agencies and ambulatory surgical facilities are reported on the basis of total state only. The study of hospital rates and charges also includes the mean for each type of service, as measured July 1, 1977 through July 1, 1978, and the percent of increase over two six month periods.

Codes and abbreviations used in the reports are listed as follows:

Codes	Abbreviations
Classification:	CBC - Complete Blood Count
	EEG - Electroencephalogram
G: Government	EKG - Electrocardiogram
M: Mining Company	ER - Emergency Room
N: Non-profit	ICU - Intensive Care Unit
P: Proprietary	IPPB Rx - Intermittent Positive Pressure Breathing

Type:

g: general
i: infirmary
s: special

IT - Inhalation Therapy
IVP - Intervenous Pyelogram
LTC - Long Term Care Beds
PT - Physical Therapy
RU - Routine Urinalysis
w/ - with

Reports for institution categories are attached as follows:

Exhibit A: Licensed non-federal hospitals
Exhibit B: Licensed nursing homes and skilled nursing facilities
Exhibit C: Licensed personal care homes
Exhibit D: Home health agencies
Exhibit E: Ambulatory surgical facilities

Report prepared by:

Ralph A. Sherman
Bureau of Health Economics
Department of Health Services

August 15, 1978

COMPARATIVE STUDY OF CHARGES

LICENSED NON-FEDERAL HOSPITALS

STATE OF ARIZONA

Hospital	Location	Description				Charges - Selected Services (in effect as of 7-1-78) (2)																						
		Classification	Type	No. of Licensed Beds	Effective Date of Price Schedule	Room - Private	Room - Semi - Private	Room - Ward	Nursery - Regular	Cardiovascular - Intensive Care	ICU - with Monitor (See Footnote Below)	Surgery - Major (1st Hour)	Surgery - Minor (1st Hour)	Labor and Delivery Room (base Charge)	Emergency Room (Minimum Charge)	EEG	EKG	Lab. - CBC	Lab. - BU	Radiology - Chest - 1 View	Radiology - Upper GI Series	Radiology - IVP	Inhalation Therapy IPPB (Ea.)	Nuclear Medicine - Brain Scan	Nuclear Medicine - Lung Scan	Physical Therapy - (One Modality)
MARICOPA COUNTY																												
Less than 50 Beds																												
ASU Student Health	Tempe	G	1	16	8-75			33.15 *									10.00*	3.00*	2.00*	5.00*							
Comm. Hospital Ass'n., Inc.	Wickenburg	N	g	34	3-78	77.00	77.00		40.00			100.00	90.00	100.00	10.00		22.00	8.00	5.00	16.00	53.00	46.00	7.00			9.00
Comm. Hospital - Chandler	Chandler	N	g	42	1-78	90.00	85.00	80.00	45.00			100.00	100.00	130.00	20.00		22.00	8.00	5.50	9.50	28.25	25.00	8.00			
St. Luke's - West	Phoenix	N	s	20	2-78	82.50*	77.50*																			
Scottsdale Community	Scottsdale	P	g	34	10-77	92.00	84.00	79.00			(125.00)	105.00	95.00		15.00		24.00	9.12	4.56	15.40	53.90	58.52	7.00			9.00
Mean						86.33	82.00	79.50	42.50		125.00	101.67	95.00	115.00	15.00		22.67	8.37	5.02	13.63	45.05	43.17	7.33			9.00
50 to 199 Beds																												
Arizona Children's Hosp.	Tempe	G	s	162	3-75		78.00					140.00	140.00				20.00	7.00*	4.00*	7.00*	30.00*	26.00*				9.00
Camelback **	Phoenix	N	s	89	7-78	137.75*	125.75*									65.00	22.50			18.00	58.00	63.00				
Glendale Samaritan	Glendale	N	g	62	1-78	92.25	86.25	83.25	33.00		221.75	149.75	85.50	128.30	29.50	80.00	26.00	10.40	6.95	12.55	57.55	55.05	10.90	130.10	130.10	9.00
Maryvale Samaritan	Phoenix	N	g	256	1-78	92.25	84.25	82.25	38.00		221.75	140.00	90.00	120.00	25.00	75.00	28.00	10.55	4.95	15.00	55.00	55.00	9.00	125.00	115.00	9.00
Memorial	Phoenix	N	g	160	2-78	110.00	99.00	90.00	45.00		240.00	135.00	93.00	135.00	25.00	85.00	25.00	12.72	6.36	16.00	55.00	55.00	8.00	106.50	106.50	10.50
Mesa General	Mesa	P	g	105	7-78	101.00	94.00	89.00	28.00		200.00	115.00	115.00	100.00	15.00	65.00	27.50	9.40	6.70	16.50	68.00	66.00	8.50	125.00	140.00	11.00
Phoenix Community	Phoenix	P	g	50	7-78	95.00	85.00	85.00			187.00	96.35	72.60		22.00	77.00	22.15	9.45	6.20	17.50	49.95	49.95	7.20	141.20	129.60	7.20
Tempe Community	Tempe	N	g	110	3-78	90.00	85.00		40.00		200.00	100.00	90.00	105.00	20.00		25.00	10.00	7.50	13.00	47.00	35.00	8.50			8.50
Valley View Community	Youngtown	N	g	56	5-78	92.40	79.20				192.00	145.20	145.20		20.40	72.60	26.40	15.85	6.60	21.60	64.80	75.60	10.20			12.00
Mean						115.81	86.34	85.90	36.80		208.86	127.66	103.91	117.66	22.41	74.23	24.73	11.19	6.46	16.26	56.66	56.82	8.90	125.66	124.24	9.52
200 to 399 Beds																												
Boswell Memorial	Sun City	N	g	261	9-77	96.00	81.00			199.00	221.00	145.80	145.80		24.00	44.12	20.00	9.70	5.82	11.92	47.68	47.60	6.62	99.36	99.36	11.60
Desert Samaritan	Mesa	N	g	273	1-78	97.25			54.00	254.25	254.25	142.35	142.35	144.10	27.50	79.95	29.40	13.55	7.45	14.35	49.95	38.60	8.60	110.55	127.30	10.00
Doctors Hospital	Phoenix	P	g	314	1-77	97.00	85.00	78.00	46.00		220.00	125.00	100.00	135.00	35.00	60.00	25.00	9.84	4.92	16.00	64.00	64.00	7.50	176.00	148.00	11.00
John C. Lincoln	Phoenix	N	g	214	1-77	81.00	75.00		41.00		147.00	100.00	86.00	130.00	22.00	61.25	25.00	9.00	5.00	19.00	55.00	50.00	7.00	105.00	105.00	10.00
Mesa Luthern	Mesa	N	g	266	1-78	97.00	97.00		47.00		209.00	107.00	100.00	137.00	24.00	60.00	24.00	8.90	6.30	12.75	40.00	40.00	7.35	107.00	110.00	8.35
Phoenix Baptist	Phoenix	N	g	221	10-77	97.50	89.50	84.50	45.00		202.50	120.00	95.00	135.00	25.00	65.00	25.00	9.45	6.40	13.75	33.00	51.70	5.90	75.00	75.00	9.20
Phoenix General	Phoenix	N	g	301	1-78	100.00	92.00	90.00	40.00		189.00	126.00	126.00	130.00	25.00	65.00	22.00	9.85	6.09	15.96	63.74	63.74	6.00	121.00	110.00	8.75
Scottsdale Memorial	Scottsdale	N	g	340	3-78	96.00	89.00	78.50	45.00	240.00	240.00	130.00	115.00	125.00	25.00	55.00	25.00	9.00	5.75	15.00	57.00	53.00	7.00	120.00	100.00	9.80
Mean						95.46	86.93	82.75	45.43	231.08	210.34	124.52	113.77	133.73	25.94	61.29	24.42	9.91	5.96	14.84	51.29	51.09	6.99	114.23	109.33	9.85
400 and Over Beds																												
Arizona State Hospital	Phoenix	G	s	800	4-27			55.20*																				
Good Samaritan	Phoenix	N	g	695	1-78	136.25	103.25		57.00	300.00	296.25	150.00	120.00	217.00	30.00	71.50	27.50	12.50	7.70	16.15	54.02	56.80	9.50	125.00	114.00	9.50
Maricopa County Hosp.	Phoenix	G	g	495	1-78			95.80	67.00		268.50	223.00	140.80	221.20	41.25	66.60	13.00	6.70	5.00	16.50	65.50	65.50	5.50	97.00	100.00	11.20
St. Joseph's	Phoenix	N	g	591	7-78	123.00	103.00	100.00	56.00	305.00	285.00	148.00	148.00	160.00	32.00	50.00	22.00	9.40	4.70	16.56	57.96	57.96	8.20	122.04	122.04	10.00
St. Luke's	Phoenix	N	g	400	2-78	110.25	100.25			442.25	282.25	167.00	117.00		25.00	80.00	75.00	11.28	5.64	15.32	73.57	88.91	7.50	82.63	59.02	11.30
Mean						123.12	102.16	97.90	60.00	349.08	283.00	172.00	131.45	199.40	32.06	67.53	21.88	9.97	5.76	16.11	62.76	67.24	7.60	105.41	98.76	10.50
Total Maricopa County																												
Mean						104.90	88.18	85.79	45.12	290.08	234.56	130.89	110.97	138.39	24.44	67.37	23.96	10.12	5.95	15.40	54.34	54.86	7.74	115.52	111.23	9.77
Range: Low						77.00	75.00	78.00	28.00	180.00	125.00	96.35	72.60	100.00	10.00	44.12	13.00	6.70	4.56	9.40	28.25	25.00	5.50	75.00	59.02	7.20
High						136.25	103.25	100.00	67.00	442.25	296.25	223.00	145.80	221.20	41.25	85.00	29.40	15.85	7.70	21.60	73.57	88.91	10.90	176.00	148.00	11.80

Footnote: Bracketed, (---), ICU Charges indicate Charges made by hospitals for ICU/CCU Services and not having ICU/CCU beds designated on license.

* Not included in Means or Ranges.

** Camelback room charges include all normal Psychiatric services and are not included in Means or Ranges.

Hospital	Location	Description				Charges - Selected Services (In effect as of 7-1-78) ($)																				
		Classification	Type	No. of Licensed Beds	Effective Date of Price Schedule	Room - Private	Room - Semi-Private	Room - Ward	Nursery - Regular	Cardiovascular - Intensive Care	ICU - with Monitor (See Footnote P&.1)	Surgery - Major (1st Hour)	Surgery - Minor (1st Hour)	Labor and Delivery Room (Base Charge)	Emergency Room (Minimum Charge)	EEG	EKG	Lab - CBC	Lab - BU	Radiology - Chest - 1 View	Radiology - Upper GI Series	Radiology - IVP	Inhalation Therapy (IPPB (Rx)	Nuclear Medicine - Brain Scan	Nuclear Medicine - Lung Scan	Physical Therapy - One Modality
PIMA COUNTY																										
Less than 50 Beds																										
Law Cornelia	Ajo	H	g	33	12-77	90.00	85.00	80.00	40.00		(175.00)	135.00	90.00	135.00	18.00		22.00	9.60	4.80	18.00	63.00	68.40	6.00			12.00
Palo Verde	Tucson	N	s	34	1.78		116.00**																			
Tucson General-West Ctr.	Tucson	N	s	31	12-77	96.00*																				
U of A Student Health (a)	Tucson	G	i	16	8-75			55.00*							10.00*		72.50*	5.50*	3.50*	12.00*			3.00*			
Wilmot	Tucson	P	s	38	10-77	77.00*	67.00*									55.00*	25.00*									
Mean						90.00	85.00	80.00	40.00		175.00	135.00	90.00	135.00	18.00		22.00	9.60	4.80	18.00	63.00	68.40	6.00			12.00
50 to 199 Beds																										
El Dorado	Tucson	P	g	160	2-78	106.00	94.00				235.00	170.00	90.00		25.00	70.00	25.00	8.50	4.00	12.50	45.50	48.75	7.00	93.75	93.75	9.50
Mean						106.00	94.00				235.00	170.00	90.00		25.00	70.00	25.00	8.50	4.00	12.50	45.50	48.75	7.00	93.75	93.75	9.50
200 to 399 Beds																										
Kino Community	Tucson	G	g	213	3-77	88.00			62.00		215.00	160.00	80.00	250.00	24.00	48.00	17.50	3.84	1.92	17.00	59.50	64.60	6.50	114.00	123.50	8.00
St. Mary's	Tucson	N	g	305	7-78	115.00	104.00	90.00	80.00	295.00	295.00	179.40	94.90	150.05	27.50	70.00	25.00	9.00	6.00	14.55	58.10	58.10	9.60			8.00
St. Joseph's	Tucson	N	g	325	2-77	105.00	93.00	87.00	75.00		250.00	115.00	85.00	175.00	20.00	66.00	20.00	9.00	3.90	12.50	50.00	50.00	8.50	175.00	185.00	10.00
Tucson General	Tucson	N	g	212	12-77	112.00	102.00	98.00	83.00		255.00	170.00	87.00	167.50	19.00	70.00	22.00	14.00	6.00	17.10	68.40	68.40	8.00	110.00	140.00	9.50
University	Tucson	G	g	300	7-77	102.00	92.00	86.00	74.00	235.00	235.00	116.00	87.00	167.00	20.00	63.00	20.00	9.00	3.50	12.00	49.00	55.00	9.00	175.00	178.00	9.00
Mean						104.40	97.75	90.25	74.80	265.00	250.00	128.07	86.77	180.90	22.10	63.40	21.02	9.24	3.98	14.62	57.00	59.31	8.32	131.00	131.63	8.90
400 and Over Beds																										
Tucson Medical Center	Tucson	N	g	557	7-78	112.00	99.00	94.00	83.00	265.00	265.00	122.00	80.00	186.00	27.00	70.00	15.00	7.00	3.50	12.00	50.40	54.00	8.35	125.00	145.00	10.35
Mean						112.00	99.00	94.00	83.00	265.00	265.00	122.00	80.00	186.00	27.00	70.00	15.00	7.00	3.50	12.00	50.40	54.00	8.35	125.00	145.00	10.35
Total Pima County																										
Mean						103.75	95.57	89.17	71.00	265.00	240.63	127.17	86.37	175.07	21.93	76.17	20.89	8.91	4.03	14.45	55.49	58.40	7.87	123.79	127.54	9.54
Ranges: Low						88.00	85.00	80.00	40.00	235.00	175.00	115.00	80.00	150.00	18.00	48.00	15.00	3.84	1.92	12.00	45.50	48.75	6.00	110.00	93.75	8.00
High						115.00	104.00	98.00	83.00	295.00	295.00	160.00	94.90	250.00	27.50	70.00	25.00	14.00	6.00	18.00	68.40	68.40	9.60	175.00	185.00	12.00

(a) Charges apply to services rendered to patients other than University Students.
* Not included in Means of Ranges.
** Palo Verde room charges include all normal psychiatric services and are not included in Means or Ranges.

Exhibit A (con't)

Hospital	Location	Description				Charges - Selected Services (in effect as of 7-1-78) ($)																				
		Classification	Type	No. of Licensed Beds	Effective Date of Price Schedule	Room - Private	Room - Semi - Private	Room - Ward	Nursery - Regular	Cardiovascular Intensive Care	ICU - with Monitor (See Footnote Fg.1)	Surgery - Major (1st Hour)	Surgery - Minor (1st Hour)	Labor and Delivery Room (Base Charge)	Emergency Room (Minimum Charge)	EEG	EKG	Lab - CBC	Lab - BU	Radiology - Chest - 1 View	Radiology - Upper GI Series	Radiology - IVP	Inhalation Therapy IPPB (Rx)	Nuclear Medicine - Brain Scan	Nuclear Medicine - Lung Scan	Physical Therapy - (One Modality)
ALL OTHER COUNTIES																										
Less than 50 Beds																										
Bagdad	Bagdad	M	S	11	3-78	80.00	75.00	65.00	35.00			135.00	65.00	85.00	15.00		16.00	10.00	4.80	14.00	42.00	45.60	5.00			
Benson	Benson	N	S	22	12-77	90.00	85.00		40.00			135.00	90.00	135.00	20.00		27.75	9.60	4.80	10.00	35.00	38.00	5.00			9.00
Copper Queen	Bisbee	N	S	31	1-78	95.00	85.00		40.00			122.00	102.00	135.00	15.00		30.00	12.00	6.00	17.00	68.00	68.00	8.75			10.00
Holbrook	Holbrook	C	S	23	11-76	80.00	70.00		30.00			90.00	75.00	150.00	15.00		25.00	10.50	7.25	18.00	64.00	56.00	7.50			7.50
Kennecott	Kearny	M	S	20	2-78		80.00		45.00			125.00	95.00	130.00	10.00		25.00	10.80	5.40	19.00	66.50	72.20	3.50			
Lake Havasu City Comm.	Lake Havasu City	N	S	34	10-77	76.00	70.00		34.00		210.00	124.00	124.00	130.00	25.00		38.50	9.00	5.50	17.00	61.90	63.90	7.85			7.00
Magma Copper	San Manuel	M	S	37	6-75	60.00	55.00	50.00	25.00			90.00	60.00	65.00	10.00		15.00	8.00	3.50	15.00	45.00	52.50	4.00			7.50
Magma Copper	Superior	M	S	20	6-75	60.00	55.00	50.00	25.00			90.00	60.00	65.00	10.00		15.00	8.00	3.50	15.00	45.00	52.50	4.00			7.50
Mt. Graham	Safford	N	S	25	1-77	90.00	80.00		42.00			105.00	87.00	102.00	16.00		30.00	9.75	8.00	18.00	55.00	54.00	6.50			8.00
Nevapeche	Lakeside	N	S	35	1-78	77.50	70.00		25.00			110.00	79.40	145.00	20.00		25.00	10.80	5.40	20.00	70.00	76.00	8.50			8.00
NAU Health Center	Flagstaff	G	1	26	2-72		8.75*																			
Northern Cochise	Willcox	N	S	24	5-78	90.00	85.00		45.00			125.00	90.00	155.00	10.00		25.00	9.60	4.00	20.50	61.50	71.75	8.50			10.00
Page	Page	N	S	25	1-78	95.00	85.00	85.00	45.00			100.00	85.00	115.00	20.00		25.00	9.40	9.40	18.00	72.00	63.00				9.00
Parker Community	Parker	N	S	36	10-76	85.00	75.00		35.00			100.00	80.00	90.00	15.00		30.00	10.80	5.40	20.00	70.80	76.00	9.00			8.40
Lewis R. Pyle Memorial ***	Payson	N	S	44	7-78	75.00	70.00		35.00		(140.00)	105.00	105.00	140.00	20.00		25.00	12.00	6.00	24.00	72.00	84.00	9.00			15.00
Sage Memorial	Ganado	N	S	45	4-76		75.00		15.00			70.00	70.00	250.00	15.00		30.00	9.38	3.75	18.00	72.00	63.00	5.00			
White Mountain	Springerville	N	S	25	1-78	91.25	84.25	80.25	33.00			142.00	90.00	150.10	22.00		32.80	13.30	8.30	21.85	87.40	76.45	12.95			
Williams	Williams	N	S	27	1-78	85.00	80.00		45.00			100.00	100.00	100.00	18.00		25.00	10.00	6.00	17.00	67.00	54.00	6.50			
Winslow Memorial	Winslow	N	S	42	1-78	82.00	77.00		42.00			115.00	115.00	140.00	20.00		20.00	9.00	5.00	20.00	70.00	76.00	7.50			
Mean						81.98	75.35	66.05	35.33		175.00	110.17	87.36	126.78	16.44		25.60	10.13	5.54	17.90	62.46	63.49	7.00			8.81
50 to 199 Beds																										
Cochise County	Douglas	N	S	79	10-76	85.00	75.00		30.00		170.00	202.00	202.00	145.00	12.00		25.00	9.60	4.80	17.00	68.00	68.00	7.00			8.00
Flagstaff Community	Flagstaff	N	S	110	3-78	97.00	87.00		65.00		210.00	115.00	115.00	125.00	25.00	77.00	21.00	8.00	4.50	14.00	56.00	49.00	8.00	126.00	112.00	10.00
Gila General	Globe	G	S	80	3-77	85.00	75.00	70.00	35.00		(165.00)	120.00	95.00	130.00	15.00		30.00	10.80	5.40	20.00	70.00	76.00	9.00			9.00
Hoemako	Casa Grande	N	S	64	3-78	90.00	80.00		45.00		(185.00)	135.00	135.00	135.00	18.00	70.00	30.00	12.00	6.00	15.00	60.00	60.00	8.00			11.00
Lake Havasu City Medical Center	Lake Havasu City	N	S	54	5-77	76.00	70.00		34.00		207.00	100.00	72.00	130.00	15.00		39.00	10.50	7.00	11.00	32.00	39.00	7.00			8.00
Marcus J. Lawrence	Cottonwood	N	S	62	7-78	113.00	94.00	87.00	60.00		240.00	184.00	184.00	150.00	30.00		33.00	7.50	4.50	18.00	72.00	72.00	9.00	140.00	140.00	12.00
Miami Inspiration	Miami	M	S	54	2-78	85.00	75.00	70.00	40.00		(125.00)	125.00	100.00	120.00	20.00		30.00	10.80	5.40	16.00	56.00	60.80	8.00			9.96
Mohave General	Kingman	G	S	83	10-77	90.00	80.00		35.00		170.00	100.00	100.00	130.00	18.00		35.00	10.00	8.00	14.00	58.00	51.00	8.50	150.00	144.00	7.50
Morenci	Morenci	M	S	74	1-77	80.00	75.00		35.00			205.00	90.00	80.00	12.50		13.00	6.50	2.50	13.00	39.00	32.50	4.00			7.00
Pinal General **	Florence	O	S	74	3-78	95.00	85.00		50.00		200.00	150.00	150.00	150.00	25.00		35.00	11.04	5.52	17.00	59.50	64.60	8.50			10.00
St. Joseph's	Bisbee	N	S	57	3-78	100.00	90.00	82.00	50.00			175.00	120.00	150.00	20.00		37.00	13.00	6.50	20.50	70.00	70.00	9.50			10.00
Sierra Vista	Sierra Vista	N	S	55	7-77	90.00	80.00	75.00	40.00		(165.00)	135.00	90.00	135.00	15.00		30.00	12.00	6.00	20.00	70.00	76.00	9.00			12.00
Yavapai Community	Prescott	N	S	100	1-78	86.00	75.00		60.00		198.00	90.00	75.00	190.00	24.00		20.00	10.50	6.25	18.00	60.00	64.00	10.00			9.25
Yuma Reg. Medical Center	Yuma	N	S	164	10-77	105.00	96.00	86.00	60.00		201.50	150.00	150.00	153.00	25.00		25.00	8.50	5.00	13.80	55.20	55.20	6.75	118.80	118.80	11.00
Mean						91.21	81.21	78.33	45.64		187.63	141.86	119.66	137.36	19.61	73.50	28.79	10.05	5.53	16.24	58.98	59.86	8.02	133.70	128.70	9.62
Total - All Other Counties																										
Mean						86.29	77.91	72.75	39.84		185.82	124.03	101.58	131.41	17.83	73.50	27.00	10.10	5.53	17.17	60.94	61.90	7.41	133.70	128.70	9.26
Range: Low						60.00	55.00	50.00	15.00		140.00	70.00	60.00	65.00	10.00	70.00	13.00	6.50	2.50	10.00	32.00	32.50	3.50	118.80	112.00	7.00
High						113.00	94.00	87.00	65.00		260.00	205.00	202.00	250.00	30.00	77.00	39.00	13.30	9.40	24.00	87.40	84.00	12.95	150.00	144.00	15.00
TOTAL - STATE																										
Mean						95.28	83.57	81.69	45.34	290.78	211.15	126.93	103.12	138.99	20.70	69.78	25.09	9.95	5.49	16.18	57.84	58.89	7.59	120.50	120.88	9.50
Range: Low						60.00	55.00	50.00	15.00	180.00	125.00	70.00	60.00	65.00	10.00	44.12	13.00	3.84	1.92	9.50	28.25	25.00	3.50	75.00	59.02	7.00
High						136.25	104.00	100.00	83.00	442.25	296.25	223.00	202.00	250.00	41.25	85.00	39.00	15.95	9.40	24.00	87.40	88.91	12.95	176.00	148.00	15.00

* Not included in Means or Ranges

** Pinal General - Licensed Beds (74) includes 7 ICU Beds temporarily de-licensed.

***Formerly Payson Hospital, Inc.

MEAN CHARGES FOR SELECTED HOSPITAL SERVICES, LICENSED NONFEDERAL HOSPITALS, STATE OF ARIZONA: 7/77, 7/78, PERCENTAGE CHANGE

SELECTED SERVICES	MEAN 7/77	MEAN 1/78	7/77-1/78 % CHANGE	MEAN 7/78	1/78-7/78 % CHANGE	7/77-7/ % CHANG
Room - Private	$ 85.11	$ 89.24	4.9	$ 95.28	6.8	12.0
Room - Semi-private	76.01	80.06	5.3	83.57	4.4	10.0
Room - Ward	73.78	78.36	6.2	81.69	4.3	10.7
Nursery - Regular	41.39	43.11	4.2	45.34	5.2	9.5
Cardiovascular - ICU	273.61	280.75	2.6	290.78	3.6	6.3
ICU - w/Monitor	193.19	206.98	7.1	211.15	2.0	9.3
Surgery - Major (1st hour)	116.09	121.41	4.6	126.93	4.6	9.3
Surgery - Minor (1st hour)	91.72	96.89	5.6	103.12	6.4	12.4
Delivery Room - (Base Charge)	128.15	134.60	5.0	138.99	3.3	8.5
Emergency Room (Minimum Charge)	18.31	19.43	6.1	20.70	6.5	13.1
EEG	60.99	62.16	1.9	69.78	12.3	14.4
EKG	23.92	24.39	2.0	25.09	2.9	4.9
Laboratory - CBC	9.61	9.69	0.8	9.95	2.7	3.5
Laboratory - RU	5.10	5.31	4.1	5.49	3.4	7.7
Radiology - Chest (1 View)	15.05	15.57	3.5	16.18	3.9	6.1
Radiology - Upper GI Series	54.54	55.65	2.0	57.84	3.9	6.1
Radiology - IVP	54.07	56.79	5.0	58.89	3.7	8.9
Inhalation Therapy - IPPB (Rx)	7.14	7.27	1.8	7.59	4.4	6.3
Nuclear Medicine - Brain Scan	115.43	119.54	3.6	120.50	0.8	4.4
Nuclear Medicine - Lung Scan	110.19	114.44	3.9	120.88	5.6	9.7
Physical Therapy - (One modality)	8.96	9.25	3.2	9.50	2.7	6.0

Department of Health Services
Bureau of Health Economics
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Exhibit B

Comparative Study of Rates and Charges

Licensed Nursing Homes and Skilled Nursing Facilities - State of Arizona

Institution	Location	Description			Room Rates Per Day (as of 7-1-78) ($)			Services Included in Rate		
		Classif.	No. Lic. Beds	Eff. Date of Price Schedule	Private	Semi-private	Ward	Incontinency	Special Feeding	Ancillary Services
MARICOPA COUNTY										
Acacia Conv. Center	Phoenix	P	74	5-78	-	27.00	27.00			
American Indian	Laveen	N	72	1-78	-	29.58	-	X	X	X
Beatitudes	Phoenix	N	150	2-78	39.68	29.79	25.71	X	X	
Bel Isle	Phoenix	P	61	11-77	28.00	23.00	-	X	X	
Beverly Manor	Phoenix	P	84	2-78	36.00	28.00	25.00			
Beverly Manor *	Sun City	P	130	3-78	47.00	38.00	-	X	X	
Boyd's	Phoenix	P	47	1-77	-	20.00	20.00	X	X	
Capri	Phoenix	P	59	1-78	-	24.00	24.00			
Chula Vista	Mesa	P	55	11-76	44.00	26.00	-	X	X	X
Country Club	Mesa	P	82	6-78	37.00	26.00	25.00	X	X	
Crestview	Phoenix	N	53	7-77	54.00	27.00	-	X	X	
Desert Haven	Phoenix	P	115	1-78	54.00	27.00	25.50	X	X	
Desert Terrace	Phoenix	P	108	2-78	56.00	28.00	26.00	X	X	
Eastern Star	Phoenix	N	36	4-78		30.00	-	X	X	
Georgian Court	Phoenix	P	60	1-78	35.00	20.00	19.00	X	X	
Glendale	Glendale	P	61	5-78	30.00	28.00	-			
Golden Age	Scottsdale	P	90	2-78	40.00	26.00	26.00			
Golden Mesa	Mesa	P	109	1-72	30.00	25.00	20.00	X	X	
Good Shepherd	Peoria	N	116	9-76	36.00	28.50	-	X	X	X
Happy Happy	Phoenix	P	39	4-78	32.00	24.00	24.00	X	X	
Hayden Manor	Scottsdale	P	39	2-78	32.00	27.00	-	X	X	
Highland Manor	Phoenix	P	107	9-77	25.50	25.50	-	X	X	
Hilton	Phoenix	P	58	5-78	22.50	22.50	22.50	X	X	
Kivel	Phoenix	N	82	2-78	43.25	33.50	-	X	X	X
Medicenter	Phoenix	P	180	3-78	43.00	33.00	-	X	X	
Mesa Christian	Mesa	N	112	1-78	47.50	31.00	-	X	X	
NHE-Bells Lodge	Phoenix	P	100	4-78	42.00	24.00	23.00	X	X	
NHE-Mt. Carmel	Phoenix	P	75	3-78	-	23.50	23.50	X	X	
Orangewood	Phoenix	N	40	1-78	-	28.00	-	X	X	
Phoenix Nursing and Conv. Ctr.	Phoenix	P	140	7-78	-	30.00	-	X	X	
Royal	Mesa	N	46	10-77	-	23.00	-	X	X	
Sacred Heart Home	Phoenix	N	50	1-72	28.00	20.00	17.00	X	X	X
Scottsdale Christian Home	Scottsdale	P	59	4-78	58.00	34.75	-	X	X	
Scottsdale Nursing Center	Scottsdale	P	92	2-78	36.00	30.75	-			
Sun Valley Lodge	Sun City	N	64	5-76	-	23.83	-	X	X	
Tanner Chapel Manor	Phoenix	N	50	6-78	35.00	26.00	-	X	X	
Valley View Hosp.	Youngtown	N	48	5-78	36.00	30.00	-	X	X	
Village Green	Phoenix	P	80	2-78	34.50	24.30	-			
Waitwell, The	Glendale	P	135	1-78	-	28.00	-	X	X	
TOTAL MARICOPA COUNTY										
Mean					38.64	26.75	23.33			
Range: Low					22.50	20.00	17.00			
High					58.00	38.00	27.00			

* New Institution

Exhibit B (Con't)

Institution	Location	Classif.	No. Lic. Beds	Eff. Date of Price Schedule	Room Rates Per Day (as of 7-1-78) ($) Private	Semi-private	Ward	Services Included in Rate Incontinency	Special Feeding	Ancillary Services
PIMA COUNTY										
Arizona Elks	Tucson	N	46	9-76	-	22.00	-	X	X	X
Bonnie Brae's	Tucson	P	62	7-77	32.75	26.50	25.50	X	X	X
Devon Gables Health Care Ctr.**	Tucson	P	254	4-78	47.00	27.50	-	X	X	
Forrester's Old Pueblo Casita	Tucson	P	80	2-78	32.00	30.00	28.00	X	X	
Handmaker Geriatric Center	Tucson	N	110	1-78	40.00	30.00	-	X	X	
Hillhaven Hospice	Tucson	P	49	5-78	60.00*	55.00*	-	X	X	X
La Hacienda	Tucson	P	64	3-78	40.00	30.00	25.00	X	X	X
Leewood	Tucson	P	86	6-78	35.00	30.25	-	X	X	X
Medicenter	Tucson	P	56	10-77	53.00	43.00	-	X	X	
Posada del Sol	Tucson	G	196	10-76	-	-	23.25			
Santa Rita	Green Valley	P	70		42.00	35.00	33.00	X	X	
Santa Rosa	Tucson	P	149	2-78	50.00	30.00	26.00	X	X	
Valley House	Tucson	P	98	1-78	35.50	27.50	-			
Villa Maria Geriatric Center	Tucson	N	89	7-78	50.00	31.80	30.80	X	X	
William-Wesley	Tucson	P	64	3-78	38.00	28.00	28.00	X	X	
TOTAL PIMA COUNTY										
Mean					41.27	30.12	27.44			
Range: Low					32.00	22.00	23.25			
High					53.00	43.00	33.00			

* Hillhaven Hospice services are not comparable to other SNF Institutions, therefore Rates and Charges are not included in Means and Ranges.
** Formerly Devon Gables Nursing Home and Devon Gables Lodge.

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Exhibit B (con't)

Institution	Location	Classif.	No. Lic. Beds	Eff. Date of Price Schedule	Room Rates Per Day (as of 7-1-78) ($) Private	Semi-private	Ward	Services Included in Rate Incontinency	Special Feeding	Ancillary Services
ALL OTHER COUNTIES										
Arizona Pioneer's Home	Prescott	C	64	8-75	-	26.25	-	X	X	X
Chinle	Chinle	N	79	1-74	-	28.00	-	X	X	X
Cochise County Hosp.	Douglas	N	50	10-76	40.00	40.00	-	X	X	
Copper Queen Hosp.	Bisbee	N	16	7-76	-	40.00	-	X	X	
Desert Manor Conv. Center	Yuma	P	130	1-72	28.90	23.90	-	X	X	
Gila General Hosp.	Globe	G	69	3-77	-	40.00	-	X	X	
Globe Health Care Center*	Globe	P	70	3-78	39.00	34.00	-	X	X	
Hoemako Hosp.	Casa Grande	N	29	1-77	32.00	25.00	-	X	X	
Kingman Health Care Center	Kingman	P	80	3-78	39.00	32.00	30.00	X	X	
Marcus J. Lawrence Hosp.	Cottonwood	N	10	7-77	-	45.00	-	X	X	
Mountain View	Safford	P	120	12-77	30.00	24.00	-	X	X	
Northern Cochise Hosp.	Willcox	N	22	5-78	-	42.00	-	X	X	
Pinal County Nursing Home	Florence	G	53	1-72	-	25.00	-	X	X	
Pinal General Hosp.	Florence	C	21	5-75	-	65.00**	-	X	X	X
Prescott Samaritan*	Prescott	P	60	5-78	36.00	33.00	-	X	X	X
St. Joseph's Hosp.	Nogales	N	24	3-78	-	45.00	-	X	X	
Warfield Nursing Home	Prescott	P	50	3-78	33.25	23.00	23.00	X	X	
Winslow Conv. Center	Winslow	P	35	11-76	-	25.00	25.00	X	X	
Yavapai Community Hosp.	Prescott	N	38	1-78	49.00	44.00	-	X	X	
TOTAL ALL OTHER COUNTIES										
Mean					36.35	33.06	26.00			
Range: Low					28.90	23.90	23.00			
High					49.00	45.00	30.00			
TOTAL STATE										
Mean					39.27	29.00	24.84			
Range: Low					22.50	20.00	17.00			
High					59.18	45.00	33.00			

* New Institutions.
** Not included in Means or Ranges.

Department of Health Services
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Exhibit C

Comparative Study of Rates and Charges

Arizona State Licensed Personal Care Homes

Institution	Location	Description			Room Rate Per Day (as of 7-1-78) ($)		
		Class/f.	No. Lic. Beds	Eff. Date of Price Schedule	Private	Semi-private	Ward
GILA COUNTY							
Globe Health Care Center	Globe	P	30	3-78	-	24.00	-
MARICOPA COUNTY							
American Indian Nursing Home Section II	Laveen	N	4	1-77	-	20.55	-
Arizona Senior Guest Lodge	Phoenix	P	16	6-78	-	25.00	-
Beatitudes Lodge,The	Phoenix	N	120	2-78	23.05	17.03	-
Beverly Manor	Sun City	P	65	3-78	40.00	31.00	-
Camelot Manor *	Sun City	P	40	4-78	24.00	19.00	-
Canzona Lodge	Phoenix	P	61	3-78	21.00	19.00	-
Chula Vista	Mesa	P	45	11-76	36.00	21.00	-
Country Club Villa	Mesa	P	92	6-78	25.00	19.00	-
Crestview Lodge	Phoenix	N	13	7-77	20.00	-	-
Good Shepherd	Peoria	N	100	9-76	29.00	19.00	-
Homestead Rest Home **	Phoenix	P	13	5-78	15.29	15.29	-
Maryland Gardens	Phoenix	P	35	3-77	19.73	16.44	-
Medicenter	Phoenix	P	60	3-78	36.00	26.00	-
Mesa Christian	Mesa	N	79	1-78	35.00	23.00	-
Orangewood Special Care Unit	Phoenix	N	24	2-75	-	18.00	-
Sacred Heart Home	Phoenix	N	120	1-72	20.00	15.00	12.00
Scottsdale Christian Home	Scottsdale	P	49	4-78	41.25	24.75	-
Scottsdale Village Square *	Scottsdale	P	90	5-78	24.00	19.00	-
Shangri La Conv. Home	Phoenix	P	28	1-72	14.79	13.15	11.51
South Mountain Manor	Phoenix	P	115	1-76	21.00	17.00	17.00
Sun Terrace *	Mesa	P	40	7-78	-	19.00	-
Sun Valley Lodge	Sun City	N	50	5-76	21.67	15.83	-
Mean					25.93	19.67	13.50

* New institutions.

** Formerly Hunt's Rest Home.

Exhibit C (Con't)

Institution	Location	Description Classif.	No. Lic. Beds	Eff. Date of Price Schedule	Room Rate Per Day (as of 7-1-78) ($) Private	Semi-private	Ward
PIMA COUNTY							
Devon Gables Health Care Center **	Tucson	P	58	10-75	28.00	19.00	-
Flower Square	Tucson	P	240	1-78	36.50	19.50	-
Santa Rita	Green Valley	P	30	3-78	31.00	24.00	22.00
Stark's Sheltered Care Home	Tucson	P	17	2-72	-	9.00	-
Mean					31.83	17.87	22.00
YAVAPAI COUNTY							
Arizona Pioneer's Home	Prescott	G	116	8-75	26.25	-	-
Prescott Samaritan	Prescott	P	20	6-78	-	22.00	-
Warfield Manor	Prescott	P	45	3-78	33.25	8.00	18.00
Mean					29.75	20.00	18.00
TOTAL STATE							
Mean					27.03	19.59	16.10
Range: Low					14.79	9.00	11.51
High					41.25	31.00	22.00

** Formerly Devon Gables Lodge.

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Exhibit D

Comparative Study of Rates and Charges

Arizona State Home Health Agencies

(as of 7-1-78) ($)

Institution[a]	Location	Classif.	Eff. Date of Price Schedule	RN Visit	LPN Visit	Aide Visit	Medical Social Worker	Physical Therapy Service & Instr.
Boswell Memorial Hospital	Sun City	N	7-78	26.00/ 5.00(b)	22.00/ 4.00(b)	20.00/ 4.00(b)	28.00/ 10.00(g)	32.00/ 7.50(c)
Cochise County	Bisbee	G	1-72	14.00	14.00	7.00	20.00	10.00
Cocolnio County	Flagstaff	G	1-76	20.00	20.00	16.00	28.00	20.00(d)
Good Samaritan Hospital	Phoenix	N	-	(f)	(f)	(f)	(f)	(f)
Maricopa County Hospital	Phoenix	G	3-76	20.00		20.00	20.00	20.00
Mesa Luthern Hospital	Mesa	N	1-78	31.40(h)	31.40(h)		31.40(h)	31.40(h)
Mohave County	Kingman	G	1-75	16.00	16.00	13.00		
Pima County	Tucson	G	1-76	22.00	22.00	17.00		18.30(f)
VNA Home Health Services	Tucson	N	3-78	25.00	25.00	19.00	30.00	30.00
Visiting Nurse Service, Inc.	Phoenix	N	6-77	23.00	23.00	20.00	32.00	32.00
Yavapai County	Prescott	G	7-76	18.00	18.00	13.00		18.00
Yuma County	Yuma	G	2-78	23.50(e)	23.50(e)	3.87(a)		23.50(e)
Mean				21.72	21.49	14.89	27.05	23.52
Range: Low				14.00	14.00	7.00	20.00	10.00
High				31.40	31.40	23.50	32.00	32.00

Notes:

(a) Charges are per visit or procedure unless otherwise indicated.
(b) First amount is base charge for visit to 90 minutes, second amount is charge for each additional 15 minutes.
(c) First amount is base charge for visit to 45 minutes, second amount is charge for each additional 15 minutes.
(d) Base charge for visit to 30 minutes, plus $6.00 for each additional 15 minutes.
(e) Indicates full charges, however actual charge is based on family size and income.
(f) Varies - Contract charge plus handling charge, if any.
(g) First amount is base charge for visit to 60 Minutes, second amount is charge for each additional 60 minutes
(h) Actual charge is made in increments of 15 minutes at $7.85.

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Bureau of Health Economics
August 15, 1978

Comparative Study of Charges

Arizona State Ambulatory Surgical Facilities

(as of 7-1-78) ($)

Facility	Location	Classif.	Eff. Date of Price Increase	Ears, Nose and Throat: Adenoidectomy and Myringotomy	General Surgery: Skin Lesion-Excision	General Surgery: Breast Masses-Excision	Gynecology: D & C	Gynecology: Laparoscopy	Urology: Cystoscopy	Plastic Surgery: Augmentation Mammography-Bilateral
Arizona Medical Plaza Surgery, Inc.	Phoenix	P	9-75	128.00	102.00	157.00	125.00	168.00	120.00	183.00
John C. Lincoln Hospital	Phoenix	N	7-77	140.00	110.00	160.00	130.00	180.00	--	215.00
Phoenix Baptist	Phoenix	N	8-76	125.00	90.00	155.00	125.00	160.00	115.00	185.00
Phoenix General	Phoenix	N	1-78	143.00	99.00	154.00	138.00	176.00	121.00	193.00
Phoenix Surgical	Phoenix	P	8-76	135.60	112.80	165.60	135.60	175.20	123.60	206.40
Scottsdale Memorial	Scottsdale	N	7-76	123.00	97.00	165.00	123.00	205.00	123.00	185.00
SurgiCenter	Phoenix	P	7-77	156.00	115.00	170.00	156.00	204.00	142.00	237.00
Tucson Medical Center	Tucson	N	7-77	155.00	110.00	110.00	110.00	183.00	110.00	239.00
2000 Place Prof. Surg. Ctr.	Tempe	P	9-76	115.00	102.00	165.00	125.00	205.00	120.00	185.00
Mean				135.62	104.20	155.73	129.73	184.02	121.83	203.16
Range: Low				115.00	90.00	110.00	110.00	160.00	110.00	183.00
High				156.00	115.00	170.00	156.00	205.00	142.00	239.00

Department of Health Services
Bureau of Health Economics
August 15, 1978

APPENDIX D

Persons Who Provided Information Used In This Case Study

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PERSONS WHO PROVIDED INFORMATION USED IN THIS CASE STUDY

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